

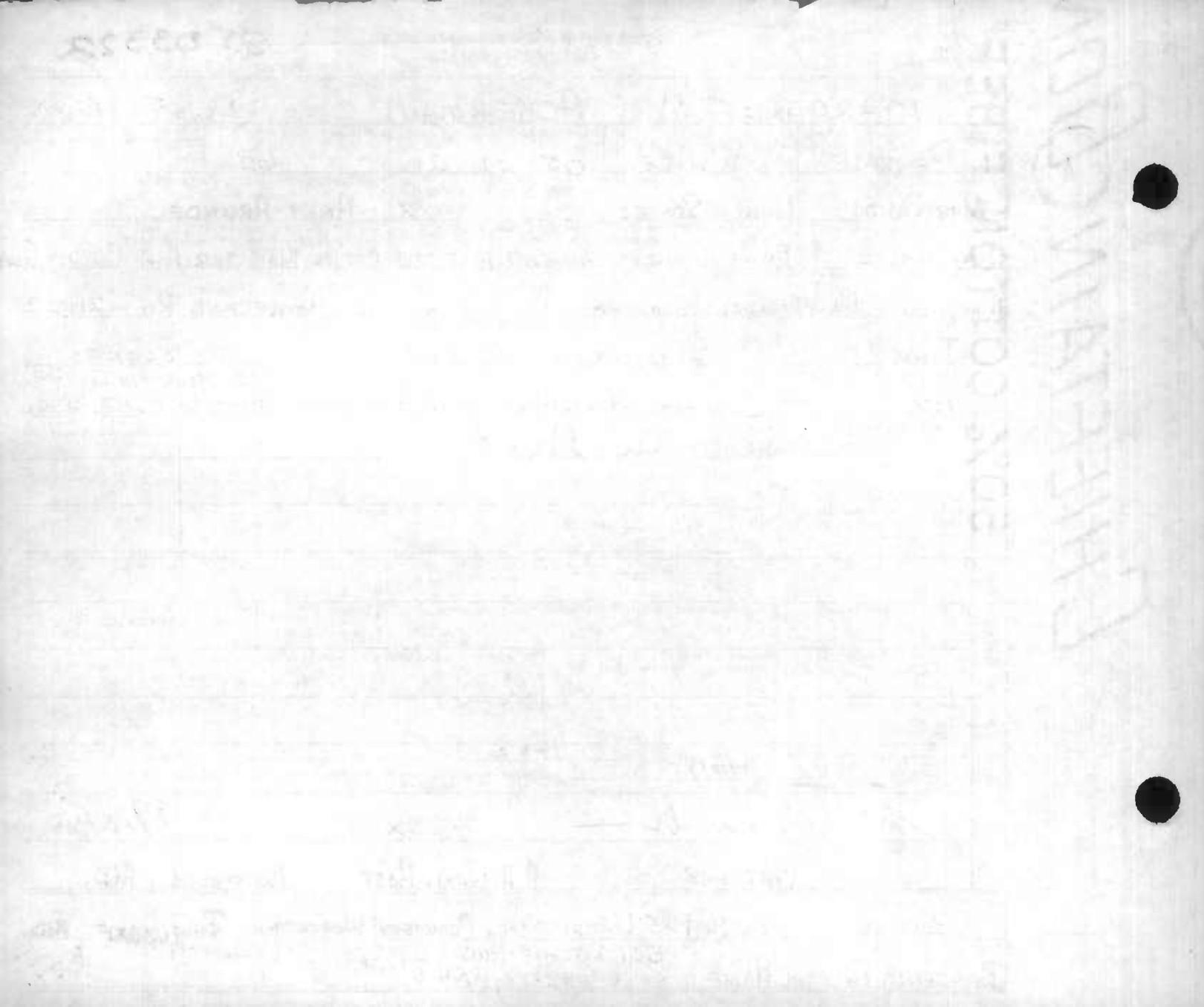
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon paper. Page 2 should be filed with the Health and Mental Hygiene Department.

IMPORTANT: If item 21 is marked on Item 1B, show any injury, greater than a traumatic event, the medical examiner must be informed.

### MEDICAL CERTIFICATION

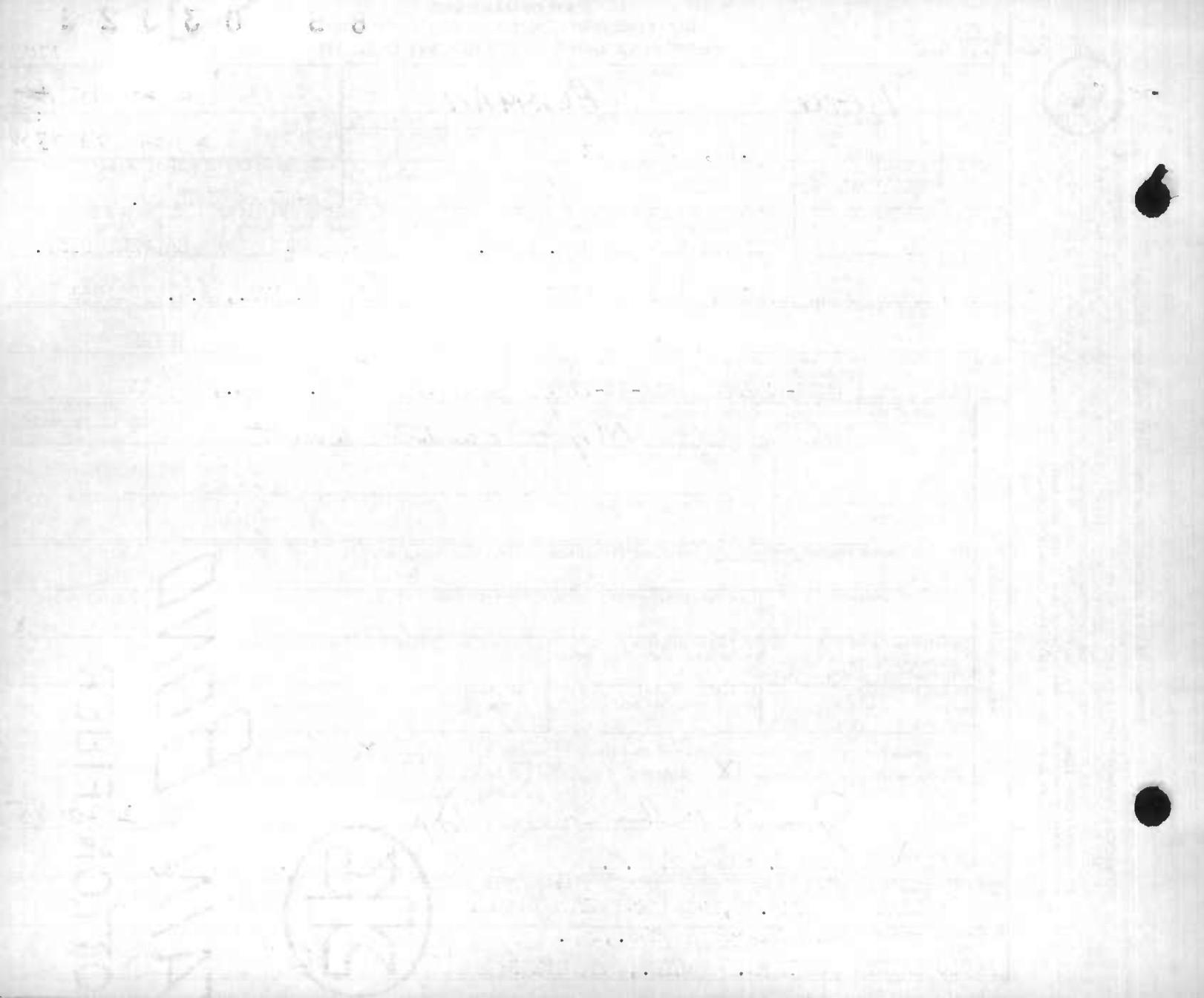
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 8503323												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	
MARGARET M					ACKERMAN	2/13/85						
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			2d. HOUR		
Female			White	Month	Day	Year	IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND			UNITED STATES						ANNE ARUNDEL			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
ANNAPOLIS			ANNE ARUNDEL GENERAL HOSPITAL			OFFICE MANAGER			A.A. COUNTY Govt			
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MARYLAND			ANNE ARUNDEL			PASADENA			15 HOMELAND RD 21122			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST			
JOHN					SCHMINCKE	IRENE			SCONES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO			215-24-6761			M. GERALD ACKERMAN			1813 MOUNTAIN TOP DR. ANNAPOLIS, MD. 21461			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>In Breast</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____						
22a. I certify that (I) (this hospital) attended the deceased from <i>1982</i> , 19_____, to <i>1985</i> , 19_____, that (I) (we) last saw the deceased alive on <i>2/13/85</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>M. Watson Jr.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>2/13/85</i>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS			A.A. GEN. HOSP. ANNAPOLIS, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			
Burial			FEB. 16, 1985			LORRINE PARK CEMETERY			Woodlawn			
24. FUNERAL DIRECTOR NAME			501 RITCHIE Hwy			25a. DATE REC'D. BY REGISTRAR			25b. SIGNATURE			
BARRANCO FUNERAL HOME			SEVERNA PARK, MD.			FEB. 20, 1985						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.

TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILE. PAGE 4 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												03325		
												REG. NO. 1700		
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/> MONTH DAY YEAR 2b. HOUR <input checked="" type="checkbox"/> 20 45 AM					
			VICTOR			ACKMAN			2 w 20 1985					
3. SEX RACE			4. DATE OF BIRTH MONTH DAY YEAR			5. AGE (IN YEARS) IF UNDER 1 YR. (LAST BIRTHDAY)			6. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7d. FOREIGN COUNTRY		
MALE WHITE			NOV. 19, 1922			62 YRS.						2 w 20 1985		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND			USA						ANNE ARUNDEL CO.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
GLEN BURNIE			NORTH ARUNDEL GEN. HOSP.			SHIPPER			CALVERT DIST.					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
MARYLAND			ANNE ARUNDEL			GLEN BURNIE						219 4TH AVE., S.W. #21061		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES <input type="checkbox"/> WWII-ARMY			16b. SOCIAL SECURITY NO. 212-12-7707			17. INFORMANT SOL ACKMAN ADDRESS 5817 STUART AVE. BALTO., MD 21215		
JACOB AKMAN			FANNY WIENER											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:						IMMEDIATE CAUSE (a)  N/A - cardiac arrest						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>			{			DUE TO, OR AS A CONSEQUENCE OF  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE James E. Wheeler			TITLE (SPECIFY) M.D.			MEDICAL EXAMINER			DATE SIGNED 2-20-85					
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS 910 Primrose Rd. Annapolis, 21403								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE FEB. 22, 1985			23c. NAME OF CEMETERY OR CREMATORY KNESSETH ISRAEL ANSHE KOKH			23d. LOCATION OR TOWN BALTIMORE COUNTY MARYLAND					
BURIAL														
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.			ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215			25a. DATE REC'D. BY REGISTRAR FEB 22 1985			25b. REGISTRAR'S SIGNATURE June Davidson-Rendell					
20M 4/82														
DHMH - 17 (VR A15 ME (5))														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical certification must be noted above.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8503324		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
Wanelle			S.	Akonom		February 15, 1985						6:00 a.m.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		MONTH June 17 DAY 1924 YEAR		60			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Georgia		U.S.A.				Anne Arundel						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Glen Burnie		203 Maple Ave.		Homemaker			Own Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE MD.		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 203 Maple Ave. 21061				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Cosby		Maddox		Smith		Loche		Ella		Wilson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 255-38-3789		17. INFORMANT Miss Sue Akonom same as 13		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>amyotrophic lateral sclerosis</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.		
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (This hospital) attended the deceased from July 1984 to February 1985, that (I) (we) last saw the deceased alive on 10/21/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>Alan Pestronk</i>		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 2/5/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN PESTRONK		22e. ADDRESS JOHNS HOPKINS HOSP										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 18 Feb. 85		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN Dorsey		COUNTY Howard		STATE MD.		
24. FUNERAL DIRECTOR NAME James S. Kirkley Glen Burnie		25a. DATE REC'D. BY REGISTRAR FEB 19 1985						25b. REGISTRAR'S SIGNATURE <i>Johns Hopkins Hospital</i>				
(VRA 15, 4)												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death... Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If Item 21 is marked or the 18 shows 999, show 999 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8503325	EST					
1 - FOR STATE REGISTRAR					REG. NO.						
I. DECEASED NAME (TYPE OR PRINT)		FIRST <b>THELMA</b>	MIDDLE (nmn)	LAST <b>ALBRIGHT</b>	2a. DATE OF DEATH	MONTH <b>FEBRUARY</b>	DAY <b>12, 1985</b>	YEAR <b>740</b>	2b. HOUR PM		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Nov.</b> DAY <b>27,</b> YEAR <b>1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b>		MD.			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT HOSPITAL, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Brooklyn Park</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>12 Wallace Ave. 21225</b>			
14. FATHER'S NAME FIRST <b>Robert</b>		MIDDLE <b>Raeke</b>		LAST <b>Mildred</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Jockel</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		16c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ovarian Cancer</b>		17. INFORMANT (Daughter) ADDRESS <b>Mrs. Thelma Nora Schwier Annapolis, Md.</b>		16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Ovarian Cancer</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <b>1983</b> , to <b>1985</b> , that (1) (we) last saw the deceased alive on <b>2/12/1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Philip H Konits</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PHILIP H. KONITS, M.D.</b>		22e. ADDRESS <b>615 HAMMONDS LANE BALTIMORE, MARYLAND 21225</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 15, 1985</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Meadowridge Mem. Pk.</b>		23d. LOCATION CITY OR TOWN <b>Elkridge</b>		COUNTY <b>Howard</b>		STATE <b>Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>R. H. Hopkins</b>		ADDRESS <b>Singleton Funeral Home, Glen Burnie, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 14 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Jane Davidson-Randall</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, if signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	WILMA	MIDDLE	LAST	AmANTE	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR						
WILMA						AmANTE	FEB. 2, 1985				11:30 A.M.							
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female			White			MONTH DAY YEAR April 17 1920			64			MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Wisconsin			U.S.A.						Ann Arundel			MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Annapolis			AnneArundel Hospital						Section Chief			U.S. Gov't.						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE						
Maryland			Ann Arundel			Edgewater			YES <input type="checkbox"/> NO <input type="checkbox"/>			12 Wilelinor Drive 21037						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST							
Carl					Olson	Rena					Arneson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No			578-42-8951			Sofio M. Amante. Same as item 13						11 days						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 19, 83, to Feb. 2, 1985, that (I) (we) lost the deceased alive on Feb. 2, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>Ew Cole III</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>2/2/85</i>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ew Cole III</i>			22e. ADDRESS <i>51 FRANKLIN ST ANNAPL. Md.</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 2/5/1985			23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery			23d. LOCATION CITY OR TOWN Annapolis, Md.			COUNTY	STATE					
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>FEB 11 1985 John L. Johnson Jr.</i>									

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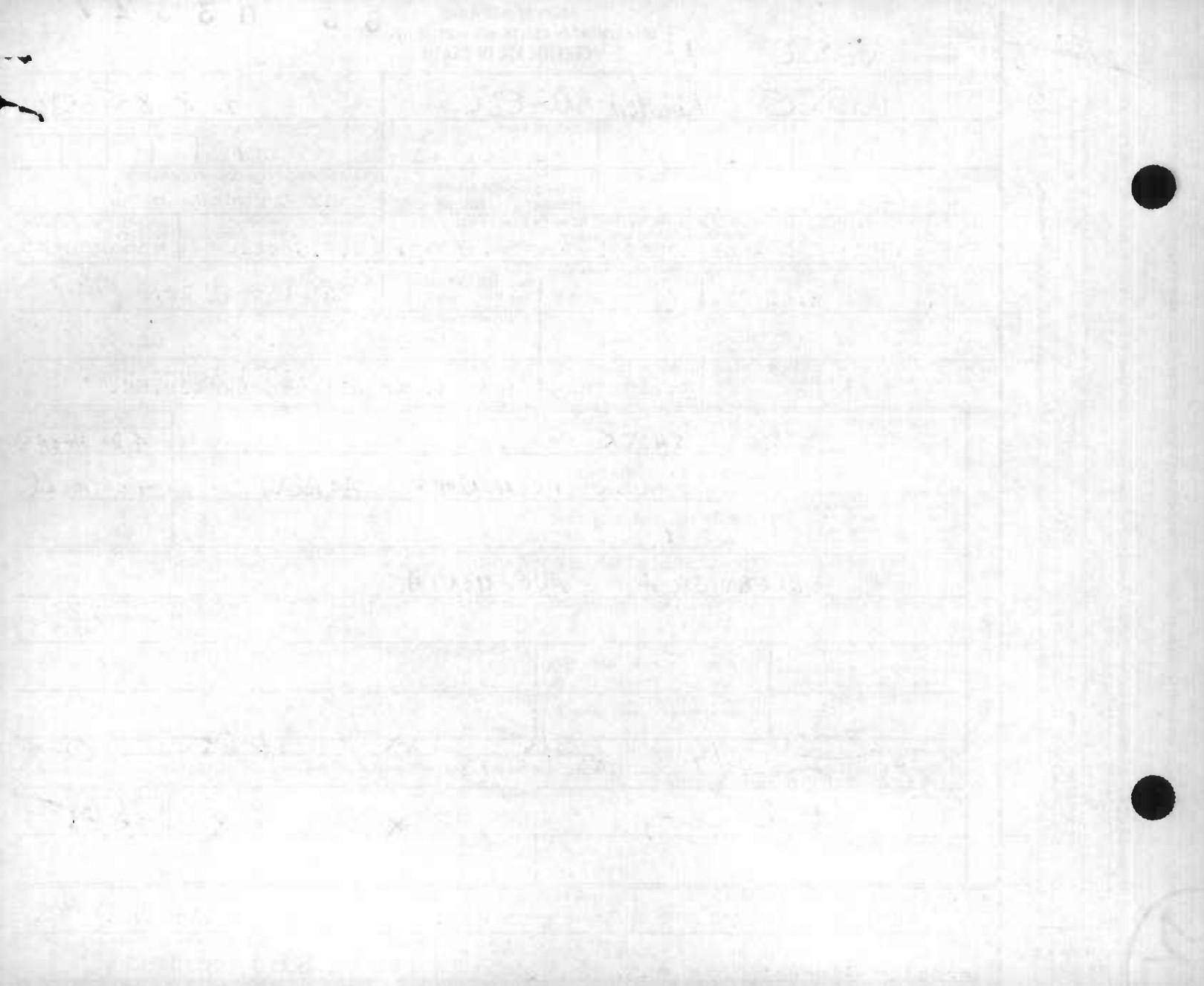
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or items 19 through 24 show any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 10-1-105 N											
1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>JESSE</b>	MIDDLE <b>N</b>	LAST <b>Newton ANGELL</b>	2a. DATE OF DEATH			MONTH 2	DAY 8	YEAR 85
3. SEX			4. RACE			5. DATE OF BIRTH			2b. HOUR		
<b>M</b>			<b>white</b>			MONTH 2 DAY 21 YEAR 85			28 85 0530		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
<b>Washington D.C.</b>			<b>U.S.A.</b>						<b>Anne Arundel Co</b>		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
<b>Annapolis</b>			<b>Anne Arundel General Hosp.</b>			<b>U.S.Govt.</b>			<b>management</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>A.A. Co.</b>			13c. CITY OR TOWN <b>Edgewater</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST <b>Jesse</b>			MIDDLE <b>Aloysius</b>	LAST <b>Angell</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b>			MIDDLE <b>A.</b>	LAST <b>Snapp</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS <b>1801 Laurel Rd.</b>		
no			<b>577-2408-95</b>			<b>Mary A. Angell</b>			<b>Edgewater, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIO - POLYPATHY ARREST</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>1</b> DUE TO, OR AS A CONSEQUENCE OF 48 HOURS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>KLEASICA PNEUMONIA</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>2/17/85</b> to <b>2/18/85</b> , 19, that (I) (we) last saw the deceased alive on <b>2/17/85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <b>Newton</b>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED <b>2/18/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN <b>Davidsonville</b> COUNTY <b>A.A.</b> STATE <b>Md.</b>		
Burial			2/11/85			Lakemont Cem.					
24. FUNERAL DIRECTOR NAME			12. ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Hardesty Funeral Home			<b>Ridgely Ave.</b>			FEB 11 1985			<b>Jesse Snapp</b>		
(VRA 15, 4)											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5 0 3 3 2 6			
										REG. NO.			
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR			
I. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		Feb 22 85		2 <sup>35</sup> P.M.		
Mabel			Reba		xc.		Austin						
3. SEX <b>Female</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>Pennsylvania</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			July 12, 1899			85 YRS				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b>			10. CITY OR TOWN OF DEATH <b>Crofton</b>			MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Crofton Convalescent Center</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home maker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			13a. STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>	
13c. CITY OR TOWN <b>Crofton</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>1408 Knightbridge Turn 21114</b>			14. FATHER'S NAME FIRST <b>Harry</b>			MIDDLE <b>A.</b>	
15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>197-09-7167D</b>			17. INFORMANT <b>Jayne Dahms-Breedon</b>			ADDRESS <b>1408 Knightbridge Turn Crofton, Maryland 21114</b>	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sepsis</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Alteemers Disease</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we did) (did not) view the body after death.			22b. SIGNATURE <i>Paul S. Rhodes</i>			DEGREE			22c. DATE SIGNED <b>Feb. 22, 1985</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul S. Rhodes MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS <b>1667 Crofton Center Crofton, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>February 25, 1985</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>George Washington Mem. Pk., Plymouth Meeting,</b>			23d. LOCATION CITY OR TOWN <b>Montgomery Co. PA</b>				
24. FUNERAL DIRECTOR NAME <b>Keith Blakes Beall Funeral Home</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 1 1985</b>			25b. REGISTRAR'S SIGNATURE <i>Davidson Pendell</i>							

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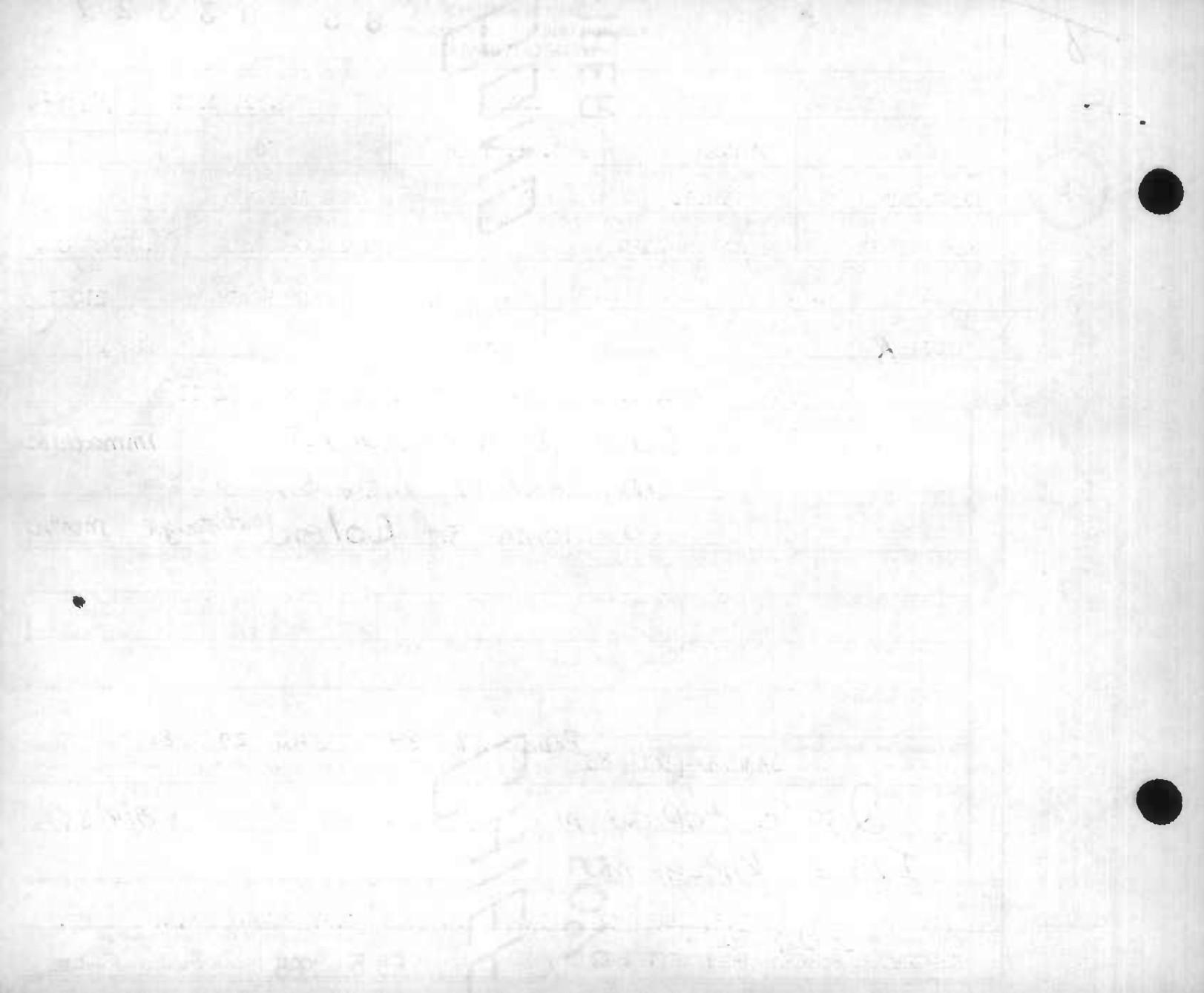
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0 3 3 2 9					
										REG. NO.					
1 - STATE REGISTRAR			I. DECEASED NAME FIRST ROBERT			MIDDLE BUZZ			LAST BAYES			2a. DATE OF DEATH FEB. 2, 1985		2b. HOUR 8:20 A.M.	
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR FEB. 21, 1924			6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.						
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 4 FOREST ROAD						12a. USUAL OCCUPATION CRANE OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY WR.GRACE CO.				
13a. STATE MD			13b. COUNTY A.A.			13c. CITY OR TOWN GLEN BURNIE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4 FOREST ROAD 21061				
14. FATHER'S NAME FIRST LEANDER			MIDDLE			LAST BAYES			15. MOTHER'S MAIDEN NAME FIRST DORA		MIDDLE			LAST ESTEP	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT (WIFE) MRS. JANE N. BAYES			ADDRESS SAME AS 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>										<i>immediate</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial infarction</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of larynx (metastasized months</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>February 8, 1984</u> to <u>JAN 27, 1985</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 21, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Ira E Kaplan, MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>2/4/85</u>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ira E Kaplan, MD</i>			22f. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <u>FEB. 5, 1985</u>			23c. NAME OF CEMETERY OR CREMATORIAL <b>GLEN HAVEN MEM. PARK</b>			23d. LOCATION CITY OR TOWN <b>GLEN BURNIE</b>		COUNTY <b>A.A.</b>		STATE <b>MD.</b>		
24. FUNERAL DIRECTOR <i>D. H. Burns</i>									25a. DATE REC'D. BY REGISTRAR <i>Julia Davidson-Pendall</i>						
									25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pendall</i>						
SINGLETON FUNERAL HOME GLEN BURNIE, MD										FEB 5 1985					



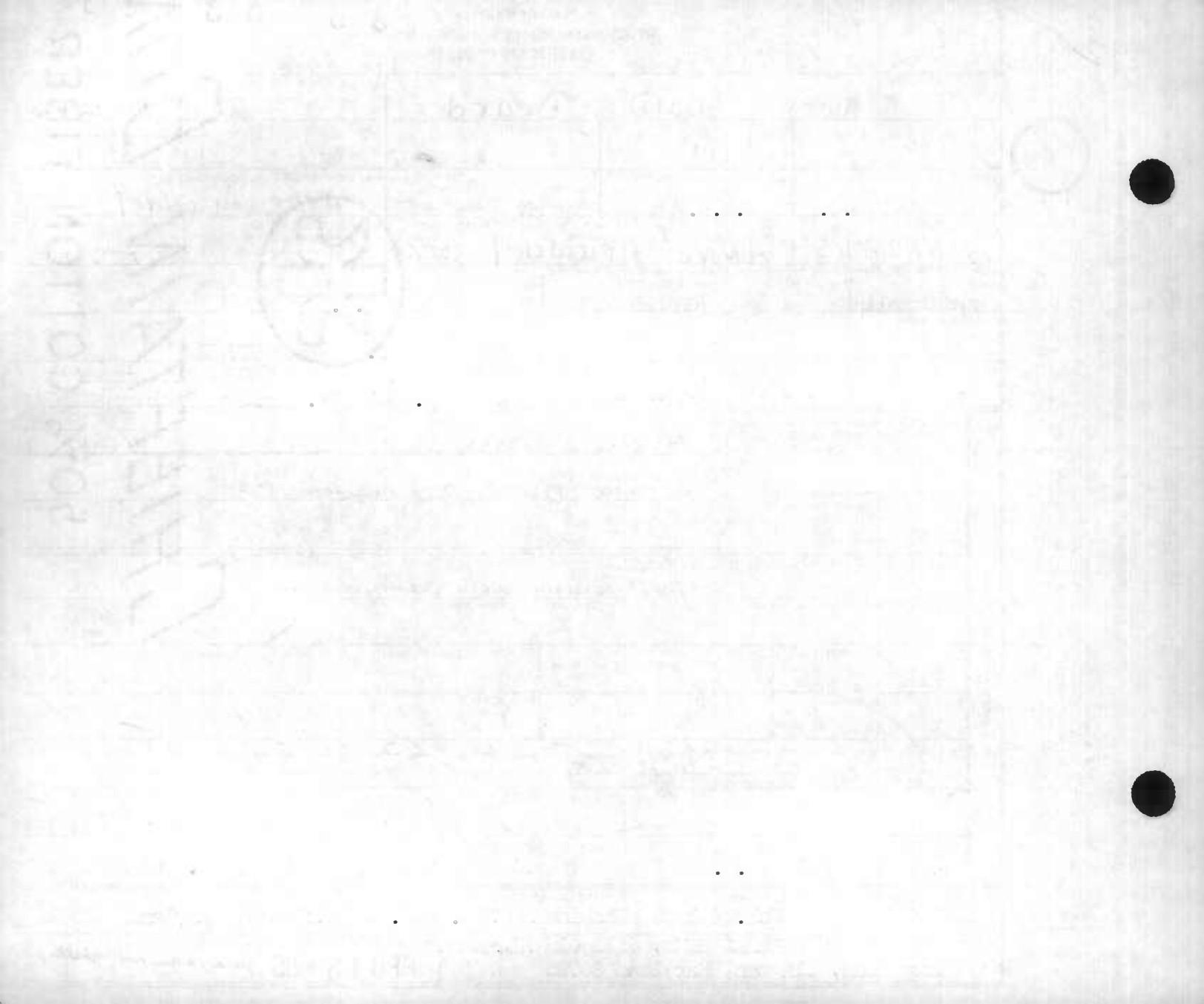
TO HOSPITAL, OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

relinquished by the hospital or attending physician.  
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Page 1 and 2 should be left within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0333
1 - FOR STATE REGISTRAR				
1a. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Mary</i>	MIDDLE <i>Wald</i>	LAST <i>Beard</i>
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH <i>7</i> DAY <i>18</i> YEAR <i>1917</i>
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WASHINGTON, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS <i>67</i> YRS DAYS HOURS MIN.
11. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ANNE Arundel Gen.</i>		
13a. STATE <i>South Carolina</i>		13c. CITY OR TOWN <i>GARDENCITY</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
4. FATHER'S NAME FIRST <i>THOMAS</i>		MIDDLE <i>KANE</i>	LAST <i>HORTY</i>	15. MOTHER'S MAIDEN NAME FIRST <i>LAURA</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>* * * 577-03-9564</i>		17. INFORMANT ADDRESS <i>George F. Wald Jr., son Camp Springs, Md 20748</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Hepatic Coma</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hepatic cirrhosis; part hepatitis - B-</i>		
		DUE TO, OR AS A CONSEQUENCE OF (c)		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hypertension with pancytopenia</i>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>2100 25 7/12</i>		21f. LOCATION STREET <i>2100 25 7/12</i> COUNTY <i>Baltimore</i> STATE <i>Md</i>
22a. I certify that (I) (this hospital) attended the deceased from soy the deceased alive on <i>2100 25 7/12</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>RICHARD PEELER, M.D.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RICHARD PEELER, M.D.</i>		22e. ADDRESS <i>51 FRANKLIN ST, ANNAPOLIS, Md. Suite #420</i>		
23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>		23b. DATE <i>Feb. 14, 1985</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Washington Nat. Cem.</i>
24. FUNERAL DIRECTOR NAME <i>LEE FUNERAL HOME, Ferry Road, Clinton, Maryland 30735</i>		24b. ADDRESS <i>6633 Old Alexander</i>		24c. DATE REC'D. BY REGISTRAR <i>FEB 13 1985</i>
				25b. REGISTRAR'S SIGNATURE <i>Jane Landon Pendall</i>



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 0 3 3 3 1			
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR									
P. DECEASED NAME (TYPE OR PRINT) <i>Erma Bell</i>			MONTH DAY YEAR			24 1985 M									
3. SEX <i>F</i>		4. RACE <i>Cau</i>		5. DATE OF BIRTH MONTH <i>12</i> DAY <i>1</i> YEAR <i>02 82</i>		6. AGE (IN YEARS) (LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i>		8. IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>		2c. DATE PRONOUNCED DEAD MONTH <i>2</i> DAY <i>4</i> YEAR <i>1985</i>		2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Illinois</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>AA</i>									
10. CITY OR TOWN OF DEATH <i>Annapolis</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel Gen.</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Supervisor</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Steel</i>						
13a. STATE <i>Md.</i>		13b. COUNTY <i>A.P.</i>		13c. CITY OR TOWN <i>Brooklyn PK</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>102 E 11th St.</i>		14. FATHER'S NAME FIRST <i>Philip</i> MIDDLE <i>Hoffman</i> LAST <i>Browning</i>			15. MOTHER'S MAIDEN NAME <i>Ella</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO.			17. INFORMANT <i>Balto.</i> ADDRESS <i>21225</i>			William Rose 102 E. 11th Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. <i>ASCVD</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i></i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET <i>St</i> CITY OR TOWN <i>Glen Burnie</i> COUNTY <i>A.A.</i> STATE <i>Md.</i>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>William P. Jones</i>		TITLE (SPECIFY) <i>Deputy</i>			MEDICAL EXAMINER										
EXAMINER'S NAME (TYPE OR PRINT) <i>William P. Jones, M.D.</i>		ADDRESS <i>695 America Cr., Davidsonville, Md. 21035</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2/8/85</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Mem Pk</i>			23d. LOCATION CITY OR TOWN <i>Glen Burnie</i>		COUNTY <i>A.A.</i>		STATE <i>Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Balto. Md.</i>			ADDRESS <i>21225</i>			25a. DATE REC'D. BY REGISTRAR <i>FEB 7 1985</i>			25b. REGISTRAR'S SIGNATURE <i>George J. Gonce</i>						
BP _____		DHMH - 17 (VR A15 ME (5))		20M 4/82											

Leads to consequences

allowable  
limits  
are still  
so far below

the critical  
level

that they are

not being met

and the effects

are becoming

more serious

and more costly

to society

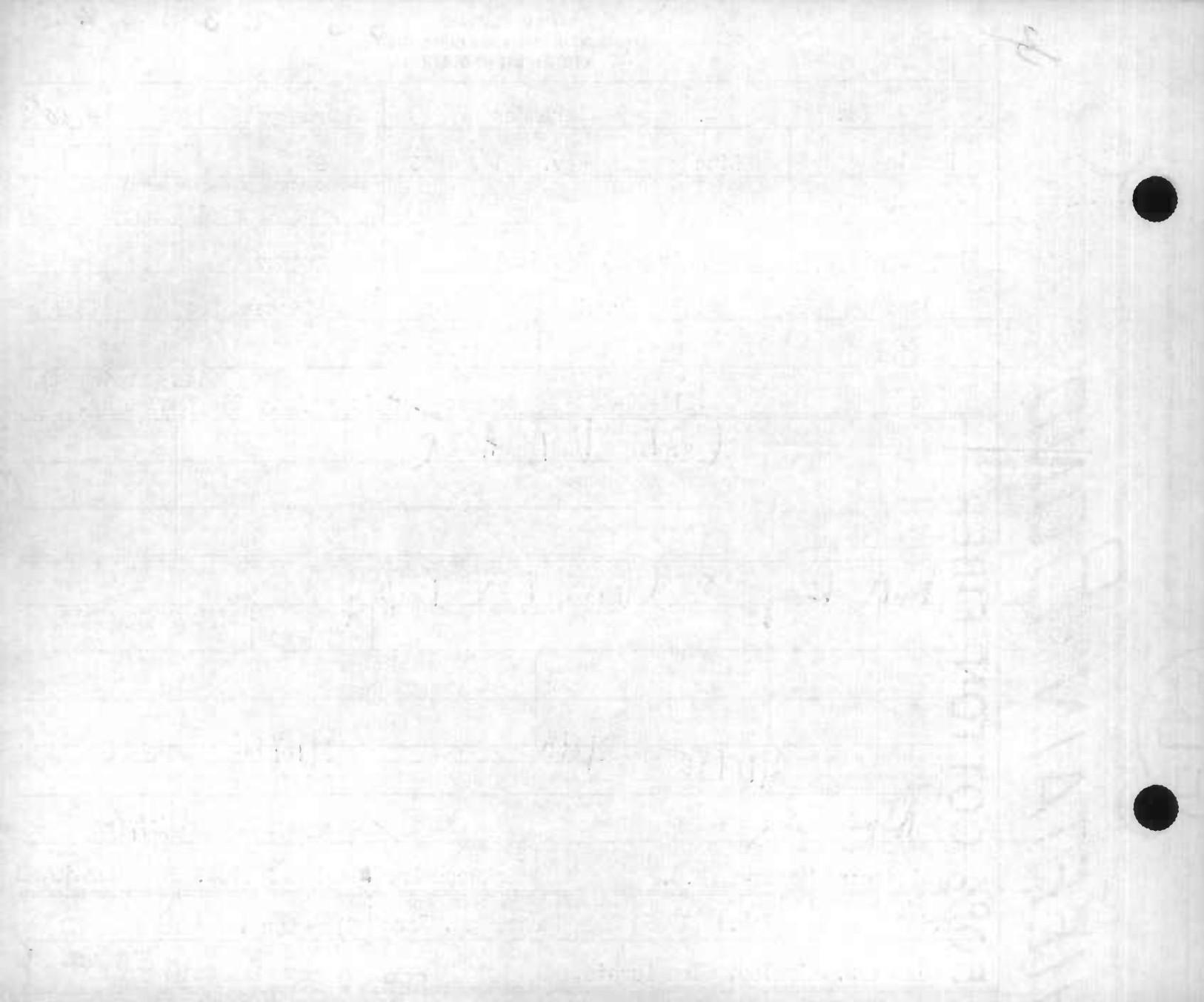
and the environment

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies (finger and 2 should be held within 24 hours after death) with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other trauma or event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 03332		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR P.M. 4:30 M		
Ida W. Berendes						February 15, 1985								
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female			White		Nov. 14, 1893			91			MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8.			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS.			
Germany			USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Anne Arundel County MD.			HOURS MIN.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Glen Burnie			North Arundel Hospital			Homemaker								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Maryland			AA		Glen Burnie			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			608 Binstead Road 21061			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						LAST		
Julius					Welz	Wilhelmine						N/A		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			215-09-4884 D			Ernest B. Deichgraber, 219 Kuethe Rd.			Glen Burnie, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)											
			DUE TO, OR AS A CONSEQUENCE OF											
			(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART Ia.														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 21/18/85, 19_____, to 21/19/85, 19_____, that (I) (we) last saw the deceased alive on 21/18/85, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Alejandro Montoya</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/19/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
Alejandro Montoya, M.D.			Oakwood Professional Bldg. Glen Burnie, MD											
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE
Burial			Feb. 18, 1985			Glen Haven Mem. Park			Glen Burnie AA			MD		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
James S. Kirkley, Glen Burnie, MD						FEB 19 1985			<i>Sue Leidner-Mandal</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending Physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked  Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 03335
1. DECEASED NAME [TYPE OR PRINT] E Evelyn Anna May Bessling			2a. DATE OF DEATH February 14, 1985		2b. HOUR M
3. SEX Female		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 15, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co.
10. CITY OR TOWN OF DEATH Odenton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 1248 Brietwert Ave			12a. USUAL OCCUPATION Housewife
13a. STATE Md.		13b. COUNTY Balt. Co.	13c. CITY OR TOWN Balt.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 704 Dorchester Rd.
14. FATHER'S NAME Christian		MIDDLE Boetker	FIRST Evelyn	MIDDLE L.	LAST Payne
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO. 214-22-4898	17. INFORMANT Vernon Bessling ADDRESS Same as #13		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cards respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Malignant Brain Tumor</i> DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19. DATE OF OPERATION 12/12/84		20. LOCATION OR WHICH OPERATION WAS PERFORMED <i>Malignant Brain Tumor</i>		21. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 1984-1985		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from now until deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>Joseph Soliman</i>					
22d. PHYSICIAN'S NAME [TYPE OR PRINT] <i>JOSEPH Soliman</i>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-16-85	23c. NAME OF CEMETERY OR CREMATORIAL Holy Cross Cem.	23d. LOCATION CITY OR TOWN Brooklyn	23e. COUNTY AACo.
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home		25a. ADDRESS Annapolis Md.	25b. DATE REC'D. BY REGISTRAR FEB 15 1985		25b. REGISTRAR'S SIGNATURE
DHMH - 16 50M 4/B3 (VRA 15, 4)					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical certification must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												0 3 3 3 4					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	26. HOUR		
CATHERINE C. BINLEY						BINLEY			FEBRUARY 4, 1985					10:45			
3. SEX <b>FEMALE</b>			4. RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 20, 1909</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MAINE</b>			7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b>			MD.					
10. CITY OR TOWN OF DEATH <b>SEVERNA PARK</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>306 EVERGREEN RD.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>								
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>ANNE ARUNDEL</b>			13c. CITY OR TOWN <b>SEVERNA PARK</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>306 EVERGREEN RD. 21146</b>					
14. FATHER'S NAME FIRST <b>JOHN</b>			MIDDLE <b>LEW</b>			LAST <b>CLARK</b>			15. MOTHER'S MAIDEN NAME FIRST <b>LENA</b>			MIDDLE			LAST <b>FREDERICKSON</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>217-58-0078</b>			17. INFORMANT <b>Bruce Binley (same as 13)</b>			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>																	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Heart Disease</b>																	
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 19, 1973</b> , to <b>Feb 4, 1985</b> , that (I) (we) last saw the deceased alive on <b>1-31-1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Donald Hislop</b>												DEGREE				22c. DATE SIGNED <b>2-5-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD H. HISLOP, M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									22e. ADDRESS <b>Robinson Rd. and Owens Way, S.P., M.D.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>Feb. 5, 1985</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>WESTVIEW CREMATORIAL</b>			23d. LOCATION CITY OR TOWN <b>WESTVIEW</b>			COUNTY		STATE			
24. FUNERAL DIRECTOR NAME <b>BARRANCO FUNERAL HOME</b>			25a. DATE REC'D. BY REGISTRAR <b>501 RITCHIE Hwy SEVERNA PARK, MD FEB 07 1985</b>			25b. REGISTRAR'S SIGNATURE <b>John Frederick Hislop</b>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 03335	EST		
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT) <b>BEATRICE JOAN BOND</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 10, 1985</b>			2b. HOUR <b>330 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 25 15</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE COUNTRY <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b>			MD.					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE <b>Repair Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co</b>								
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Linthicum Hgts</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>510 Greenwood Road 21090</b>					
14. FATHER'S NAME FIRST <b>Harry</b>		MIDDLE <b>C.</b>		LAST <b>Gammage</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b>			MIDDLE <b>Marie</b>			LAST <b>Foy</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-01-6239</b>		17. INFORMANT <b>William L. Bond</b>			ADDRESS <b>Same as 13e</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Possible myocardial infarction</b>															
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive cardiovascular disease</b>															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from <b>Oct 28</b> , 19 <b>82</b> , to <b>Oct</b> , 19 <b>84</b> , that (1) (we) last saw the deceased alive on <b>Oct</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <b>Thomas Polotsky</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>2/11/85</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thom Polotsky</b>			22e. ADDRESS <b>601 Park Ave Balto Md 21201</b>												
23a. BURIAL, CREMATION REMOVAL SPECIES <b>Entombment</b>			23b. DATE <b>2/13/85</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park Cem.</b>			23d. LOCATION CITY OR TOWN <b>Balto</b>			COUNTY <b>====</b>		STATE <b>Md</b>	
24. FUNERAL DIRECTOR <b>George J. Gonc</b>			24a. ADDRESS <b>4001 Ritchie Hgwy Balto Md</b>			24b. DATE REC'D. BY REGISTRAR <b>FEB 13 1985</b>			24c. REGISTRAR'S SIGNATURE <b>Jane Davidson</b>						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 4 WITH FORM PM. 3 RETAIN, PAGE 4 WITH FORM PM. 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1A AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 W. PRESTON ST., BALTIMORE, MD.

## MEDICAL CERTIFICATION

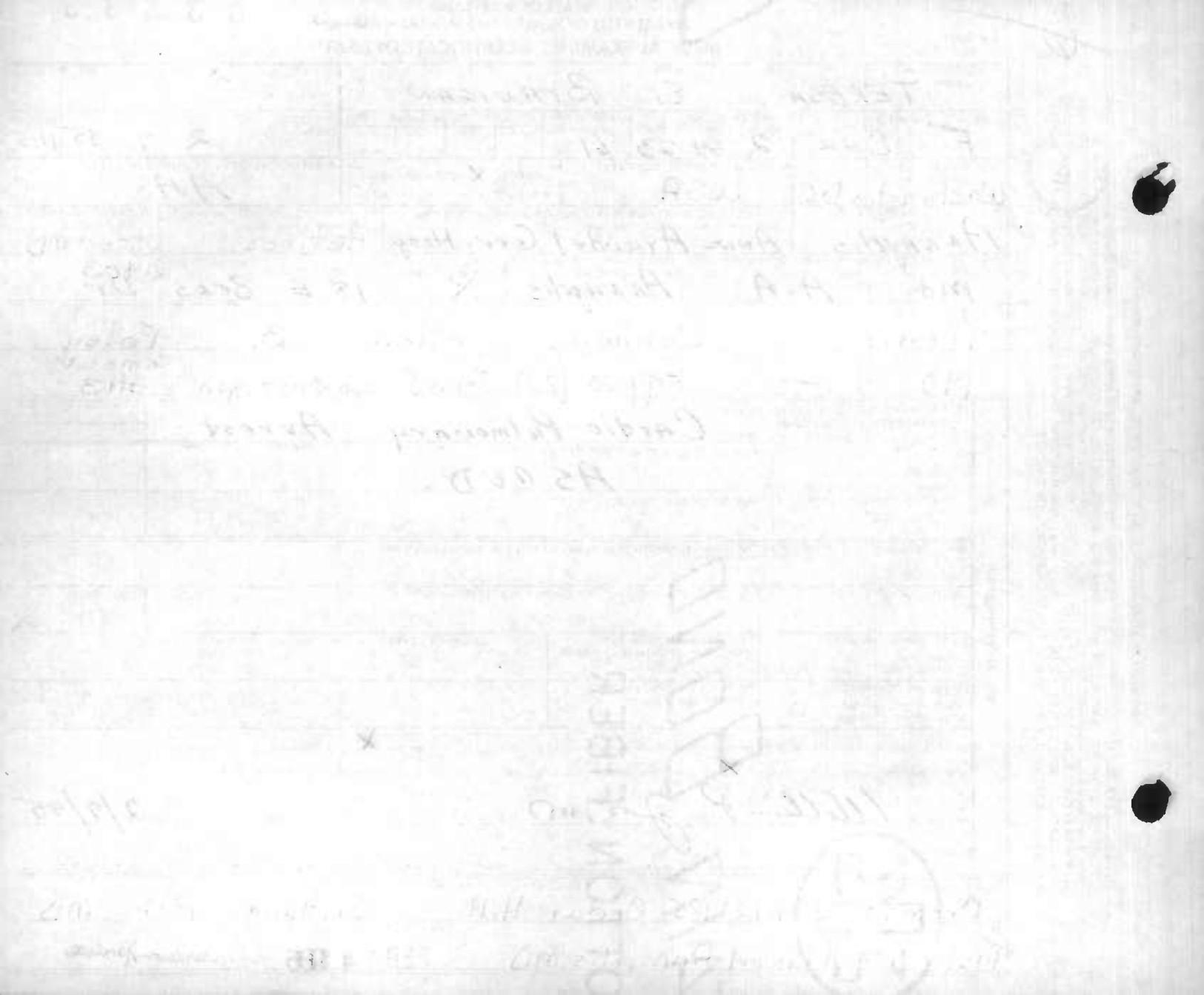
1-  
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03336

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	7a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	MONTH	DAY	YEAR	7b. HOUR 19 M		
1. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 29 85	MONTH	DAY	YEAR	7d. HOUR 1115 M		
7e. BIRTHPLACE STATE OR FOREIGN COUNTRY Washington D.C.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH AA.			
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY State of MD			
13a. STATE Md.	13b. COUNTY A.A.	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 18 E Bens Dr								
14. FATHER'S NAME FIRST Thomas			15. MOTHER'S MAIDEN NAME Connolly			16. SOCIAL SECURITY NO. 579-20-7809			17. INFORMANT John Joseph Branigan			
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (TYPE OR UNKNOWN) No			19. CAUSE OF DEATH (Enter only one cause per line) (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last (b) <u>AS CVD</u> . DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE William P. Jones, M.D.		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 3/9/85						
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.		ADDRESS 695 America Cr., Davidsonville, Md. 21035										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Feb. 12, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		23d. LOCATION CITY OR TOWN Suitland		COUNTY PG. MD		STATE		
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel		ADDRESS Annapolis, MD		25a. DATE REC'D. BY REGISTRAR FEB 14 1985		25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall						
DHMH - T7 (VR A15 ME (5)) 20M 4/B2												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 03331							
										REG. NO.							
1. FOR STATE REGISTRAR		FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MARGIE James			BRASHEARS						2a. DATE OF DEATH		2	17	85	6:30 A.M.	
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Female		White			Oct. 22, 1892			92			MONTHS		DAYS	HOURS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland		USA						Anne Arundel									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Annapolis		Annapolis Convalescent Ctr.			Homemaker												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS								
MD		A.A.		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			311 N. Glen Ave. 21401								
14. FATHER'S NAME		FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS				
Charles		S. Higgs			ELIA			214-74-2001			Olivia B. Suit-		Same as #13				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			16c. ADDRESS			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO -		-											CARDIO-RESPIRATORY ARREST		-		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC, CARDIO-VASCULAR & CHRONIC															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).										CEREBRO-VASCULAR ACCIDENT							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
								YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/>			NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (1) (this hospital) attended the deceased from JAN 1, 1985, to FEB 12, 1985, that (1) (we) last saw the deceased alive on JAN 22, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED									
BARRY R. NATKANSON MD								22e. ADDRESS				2/18/85					
22f. PHYSICIAN'S NAME (TYPE OR PRINT)																	
BARRY R. NATKANSON 51 FRANKLIN ST. ANNAPOLIS MD 21401																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Burial		Feb. 20, 1985			Mayo Memorial			Mayo		A.A.		MD					
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Taylor Funeral Chapel - Annapolis, MD					FEB 21 1985			L. Davidson-Rendell									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8503338					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	February 27, 1985							8:32A.M.		
Evelyn C. Brennan															
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR			
Female			Caucasian		Nov. 3, 1907			77 YRS.				MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.			
Washington D.C.			USA					Anne Arundel							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie			North Arundel Hospital							Secretary				US Gov't	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE			
Maryland			Anne Arundel		Crofton							1717 Hart Court 21114			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	F. ADDRESS					
Oscar			N.	Trail	Marie			F.	McCullough	12205 Mackell Lane					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Bowie, Md.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
no			577-03-3179		Thomas J. Brennan										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										cardiopulmonary arrest					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure					
										DUE TO, OR AS A CONSEQUENCE OF (c) and severe chronic obstructive lung disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from January 19, 1984, to 2/25, 1985, that (I) (we) last saw the deceased alive on 2-25, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE R. Dakheel, M.D.			DEGREE M.D.							ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2/27/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Riad Dakheel, M.D.			22e. ADDRESS 14300 Gallant Fox Ln. Bowie, MD 20715												
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial			23b. DATE Mar 2, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME Beall Funeral Home			ADDRESS 16000 Annapolis Road Bowie, Md.						25a. DATE REC'D. BY REGISTRAR MAR 1 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandell				

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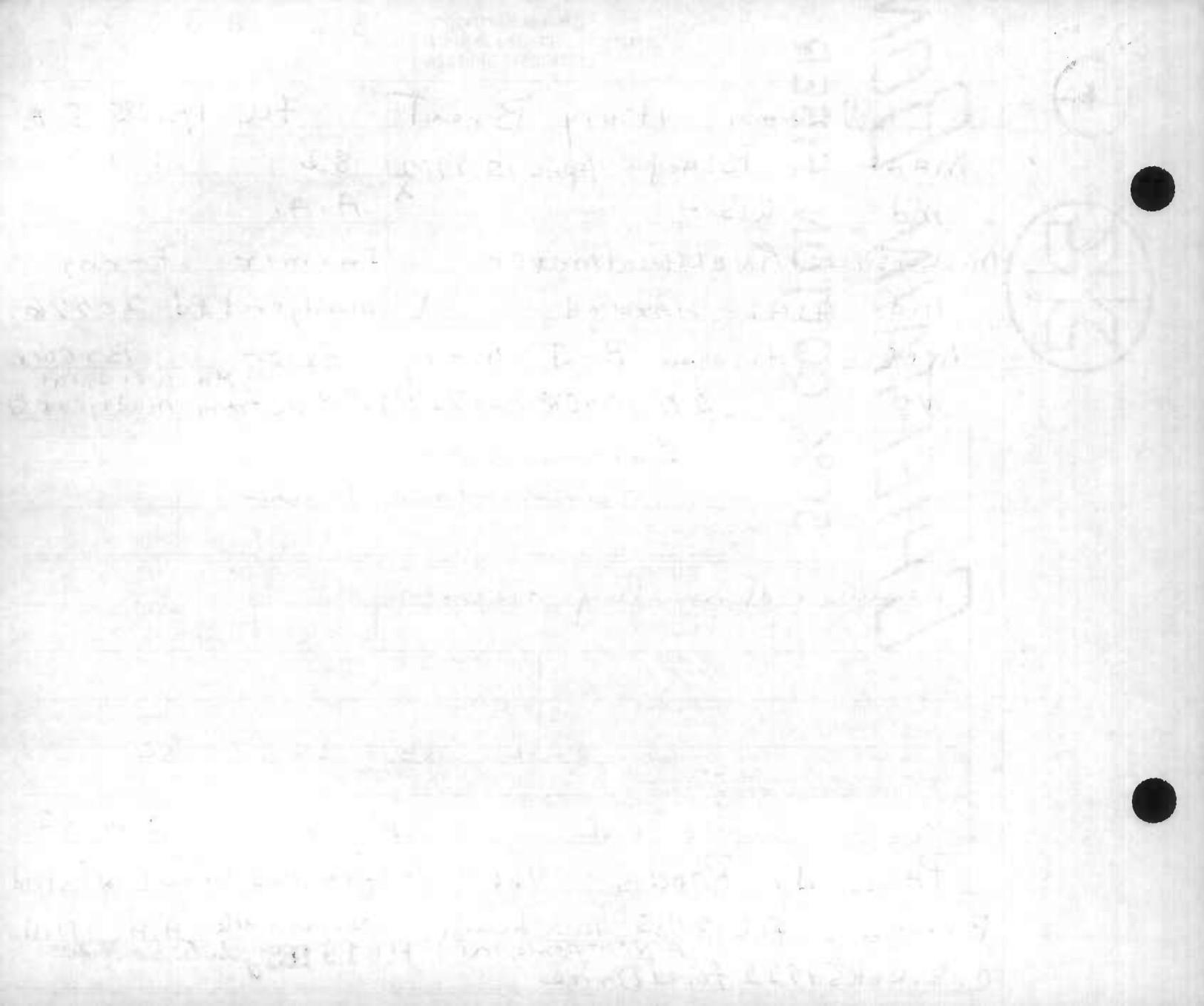
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death. In the State Dept. of Health and Mental Hygiene return to Bureau, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury or other traumatic event, the medical examiner must be consulted.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8503339			
1 - FOR STATE REGISTRAR													
I. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
William				Brent	Feb	14-1985				8:05A			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male		Black		April 15 1902			82						
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Md		U.S.A					A.A.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Millersville		Knollwood Manor										Farmer	
12b. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Md		A.A.		Harwood			X			muddy creek Rd 20776			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST		BROWNS				
Moses		Abraham	Brent	Mary		ELIZ	Brown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		6 17 30-4548		Martha Brent		Harwood, md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordless Airstat</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Dementia, chronic lung disease</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2) <u></u>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		21g. CITY OR TOWN	21h. COUNTY	21i. STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8-30</u> , 19 <u>83</u> , to <u>2-13</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2-13</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Pearl J. Rhodes</u>		22c. DEGREE <u></u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>2-14-85</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Pearl J. Rhodes</u>		22e. ADDRESS <u>1667 Crofton Med Center Crofton Md</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Feb 18-1985</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Chesapeake</u>		23d. LOCATION CITY OR TOWN <u>Millersville</u>		23e. COUNTY <u>A.B.</u>		23f. STATE <u>Md</u>			
24. FUNERAL DIRECTOR NAME <u>C. G. Hicks</u>		ADDRESS <u>1922 Forest Drive</u>		25a. DATE OF DEATH OR BURIAL <u>Feb 19 1985</u>		25b. REGISTRATION NUMBER <u>State Board of Health</u>							
BP													
DHMH - 16 60M 7/84 (VRA 15, 4)													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (Form 35), it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

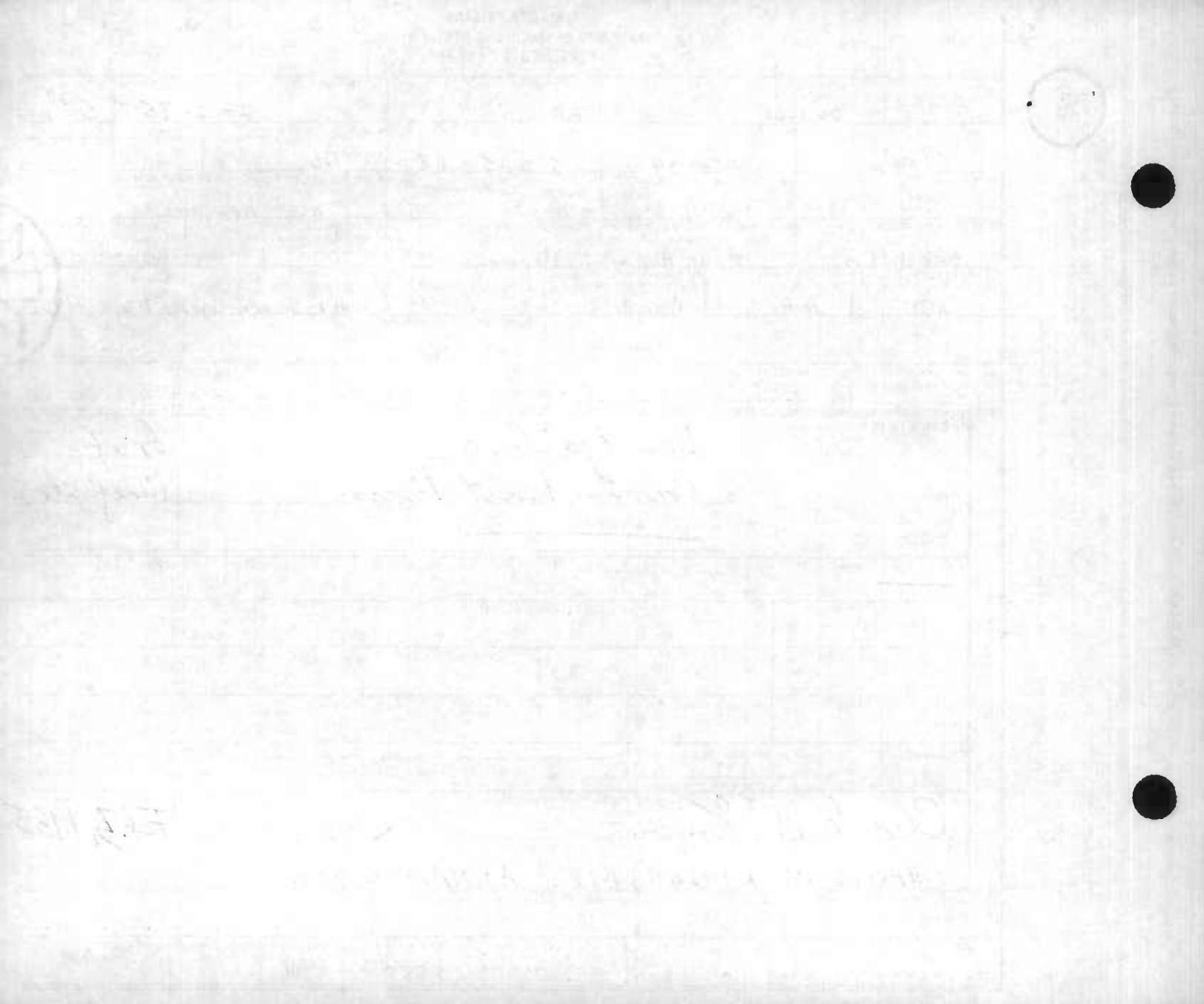
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.  
0313340

1 - DECEASED NAME (TYPE OR PRINT) <b>Martha ONALEE BROWN</b>			2a DATE OF DEATH MONTH DAY YEAR <b>2 - 2 - 85</b>	2b HOUR 5:28 P.M.
3. SEX <b>Female</b>		4 RACE <b>Caucasian</b>	S. DATE OF BIRTH MONTH DAY YEAR <b>5 - 25 - 08</b>	6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <b>76 YRS</b>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Claibourne, Tenn. U.S.A.</b>		7b CITIZEN OF WHAT COUNTRY? 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>		
13a STATE <b>MD.</b>		13b COUNTY <b>A. A.</b>	13c CITY OR TOWN <b>Annapolis</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>Tine</b>		MIDDLE <b></b>	LAST <b>Brooks</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Amanda</b>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>213-34-1917</b>	17 INFORMANT <b>Verdie Bledsoe</b>	ADDRESS <b>same as 13 e.</b>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>brief</b> <b>indefinite</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary heart disease</b>		
		DUE TO, OR AS A CONSEQUENCE OF (c) _____		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(b)				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE <b>Charles W. Kinzer</b>		DEGREE <b></b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <b>Feb 3, 1985</b>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES W. KINZER, MD.</b>		22e ADDRESS <b>ANNAPO利IS, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/5/85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Hillcrest Cemetery</b>	23d LOCATION CITY OR TOWN <b>Ann.</b>
24. FUNERAL DIRECTOR NAME <b>Hardesty Funeral Home Ann. Md. 21401</b>		12 Ridgely Ave. ADDRESS		25a DATE REC'D. BY REGISTRAR <b>FEB 4 1985</b>
				25b REGISTRAR'S SIGNATURE <b>Davidson-Kendall</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1-3 should be retained by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1-3 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

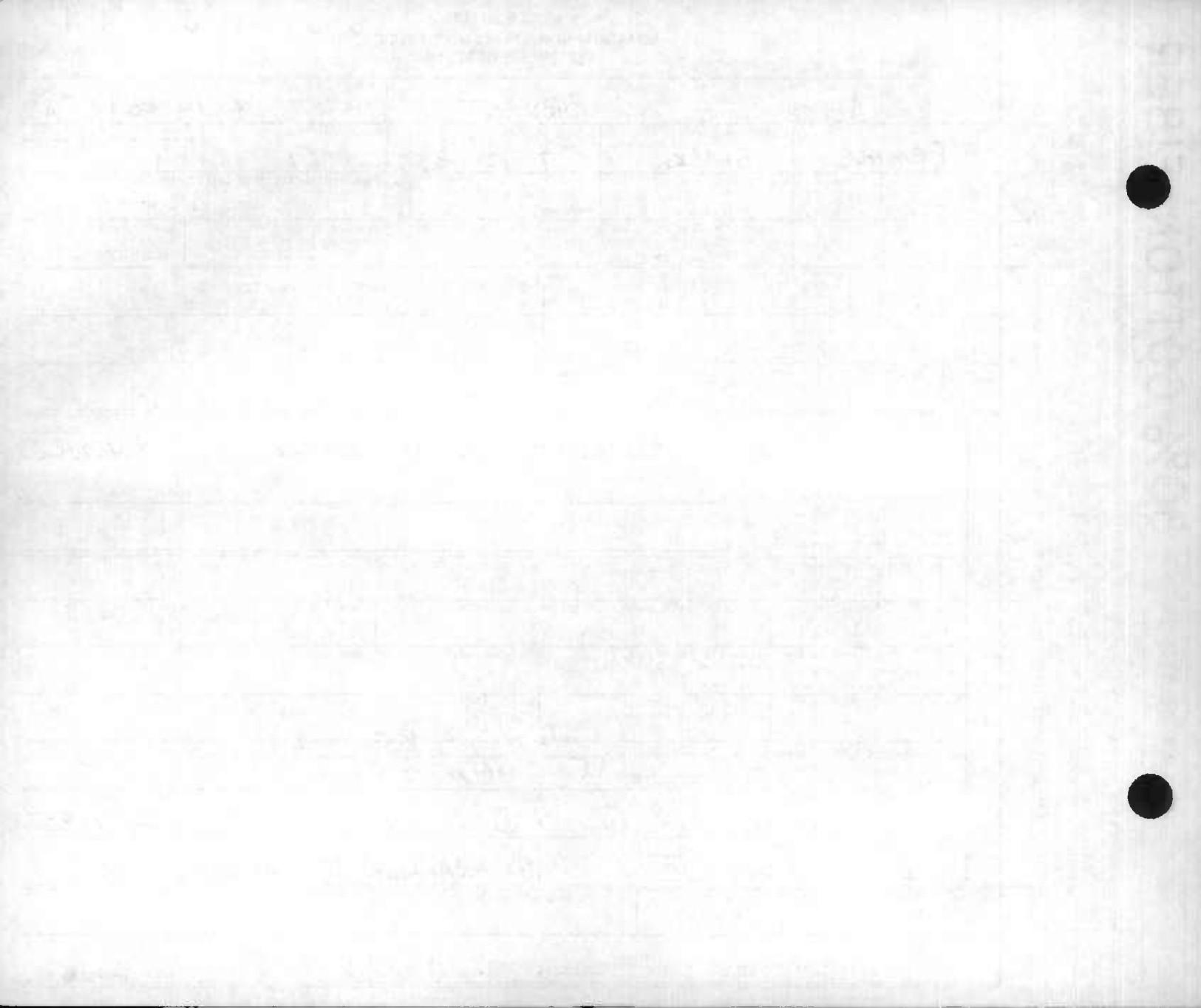
## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 85 031341

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
ALICE S BRYANT						2 10	85			7:38 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
FEMALE		BLACK		MONTH	DAY	YEAR	51	YRS	MONTHS	IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.							Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis		Anne Arundel Hosp.					Adjuster			Insurance		
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 417 Forest Beach Road 21401				
14. FATHER'S NAME FIRST Bernard		MIDDLE R.		LAST Anderson		15. MOTHER'S MAIDEN NAME FIRST Sadie		MIDDLE R.			LAST Pack	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		17. INFORMANT		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
No		212-34-4458		Metastatic Breast Cancer								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				DUE TO, OR AS A CONSEQUENCE OF (b)								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (we) attended the deceased from saw the deceased alive on (date) (time) above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE E. W. Cole III		22c. DATE SIGNED 2/10/85								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. W. COLE III		22e. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. ADDRESS 51 FRANKLIN ST ANNAPOLIS MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2/11/85		23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.		23d. LOCATION CITY OR TOWN		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board		25a. DATE REC'D. BY REGISTRAR FEB 22 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rogers								
DHMH - 16 60M 7/84 (VRA 15, 4)												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 2 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03344

REG. NO.

FOR STATE REGISTRAR		FIRST MIDDLE LAST										2a. DATE KNOWN OF ESTI- MATED				MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		Emerson Leon Burgess										<input checked="" type="checkbox"/>				19 M		19 M	
3 3		1. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				MONTH DAY YEAR		2d. HOUR			
		m	N	8 8 28	56 yrs.	MONTHS	DAYS	HOURS	MIN	2 14 85				19 M		1350 M			
7e. BIRTHPLACE FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
10. CITY OR TOWN OF DEATH		NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		2 17 16									
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	3514 Forest Pk. Ave.									
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
Yes		1946-48		218-22-5688		Mrs. Beatrice Burgess		3514 Forest Pk											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) <u>Morbid Obesity</u> DUE TO, OR AS A CONSEQUENCE OF  (c) <u>Hypertensive CVD</u>																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE		TITLE (SPECIFY) William P. Jones, M.D.										MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 695 America Crt., Davidsonville, Md. 21035																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE									
Burial		2-19-85		Garrison Forest V.A.		Garrison				Md.									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Tas. A. Morton & Sons		1701 Laurens		FEB 19 1985		John Davidson-Rendell													

1

Yesterdays weather was

mostly cloudy with a few

sunshine breaks in the

afternoon. Wind was

moderate from the

south west. Temperature

was about 70 degrees F.

Humidity was about 70%

Cloud cover was about

75% with some broken

clouds. Wind direction

was mostly from the

south west with some

wind from the south east.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (Page 3) should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 3 0 3 3 4 3			
												REG. NO.			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Frederick W. Burkmar						February 25, 1985			5:45 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		April 7, 1910			74 YRS			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Baltimore		USA					Anne Arundel County								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Glen Burnie		5 Brownshade Drive			Retired, Welder			Martin Marietta							
13a. STATE Maryland				13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5 Brownshade Drive 21061					
14. FATHER'S NAME FIRST Frederick S. Burkmar				MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE C.		LAST Ellis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. WW II		16c. INFORMANT		ADDRESS							
Yes				212-09-1809		Redora B. Burkmar, Same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Severe cardiac failure</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension, A. S. C. V. D.</u>															
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CVA.</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 11, 1961</u> to <u>June 29, 1985</u> , that (I) (we) last saw the deceased alive on <u>6-29-85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Robert Dabolins, M.D.</u>												DEGREE			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Dabolins, M.D.												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. ADDRESS 400 Crain Highway, N.W., Glen Burnie, MD												DATE SIGNED <u>2-26-85</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Feb. 28, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Park			23d. LOCATION CITY OR TOWN Glen Burnie			COUNTY AA		STATE MD	
Burial															
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD									25a. DATE REC'D. BY REGISTRAR FEB 26 1985			25b. REGISTRAR'S SIGNATURE <u>Jeanne Dabobin-Kendall</u>			

1943

July 1943 - 1943

G. S. L. A. 1943

Ans

1943 - 1943

1943 - 1943

1943 - 1943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or has a checkmark, any injury or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8503344	
												REG. NO. EST	
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			FEBRUARY 23, 1985 910 PM	
LOUISE VIRGINIA BUTLER													
3. SEX Female			4. RACE Black			5. DATE OF BIRTH MONTH 5 DAY 25 YEAR 1914			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.			13b. COUNTY A. A. Co.			13c. CITY OR TOWN Gambrills			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1129 Carver Rd. 21054	
14. FATHER'S NAME FIRST James			MIDDLE			LAST Gray, Sr.			15. MOTHER'S MAIDEN NAME FIRST Ida			MIDDLE LAST Parker	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT Lorraine Edwards			ADDRESS Odenton, Md. 21113				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute respiratory failure</i>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 d			18. DUE TO, OR AS A CONSEQUENCE OF (b) <i>end stage renal failure</i>			18. DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>2-23-85</i> , 1985, to <i>2-23-85</i> , 1985, that (I) (we) last saw the deceased alive on <i>2-23-85</i> , 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Long S. Hsu, M.D.</i>			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M.D.						22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/1/85			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Tabor Cem.			23d. LOCATION CITY OR TOWN Annapolis, A. A. Co. Md.				
24. FUNERAL DIRECTOR William Reese & Sons Mortuary A. A. Med			25a. DATE REC'D. BY REGISTRAR FFB 27 1985			25b. REGISTRAR'S SIGNATURE <i>G. Davidson Pendell</i>							
DHMH - 16 60M 7/84 (VRA 15, 4)													

7



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 03345		
1- STATE REGISTRAR			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 27 1985 M											
1. DECEASED NAME (TYPE OR PRINT) Willie Wilbert Butler			FIRST MIDDLE LAST			IF UNDER 1 YR. IF UNDER 24 HRS.			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 27 1985 1702 M					
3. SEX M		4 RACE Neg		5. DATE OF BIRTH MONTH DAY YEAR 2 1 80		6. AGE (IN YEARS) LAST BIRTHDAY 65 yrs		MONTH DAYS HOURS MIN			9 BALTIMORE CITY OR COUNTY OF DEATH AF			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10 CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 1126 Eastport Terrace		
13a. STATE Md			13b. COUNTY AF			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1126 Eastport Terr. 21403		
14. FATHER'S NAME FIRST ENOCH			MIDDLE			LAST BUTLER			15. MOTHER'S MAIDEN NAME FIRST ROSETTA			LAST BROWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			Annapolis, Md. 21403		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Cardiac Arrest						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF			(b)			AS CVD.					
			DUE TO, OR AS A CONSEQUENCE OF			(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Carcinoma of Throat														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE William P. Jones, M.D.			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER			DATE SIGNED 3-1-85					
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.			ADDRESS 695 America Cr., Davidsonville, Md. 21035											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3-4-1985			23c. NAME OF CEMETERY OR CREMATORIAL PINELAWN M.M. PARK			23d. LOCATION CITY OR TOWN Annapolis			COUNTY		STATE land
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.			ADDRESS 21401			25a. DATE DECD. BY 1980			25b. DATE REC'D. BY 1980			RECEIVED		BY
BP _____														
DHMH - 17 (VR A15 ME (5))														
20M 4/B2														

Verbal stimuli

and

Visual stimuli

and

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT): If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified at 301-727-2000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			FEBRUARY 01, 1985		1145 AM	
ELIZABETH KIRBY CERF															
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>5-16-1899</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b>			MD.			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>NORTH ARUNDEL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Salesperson</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>May Co.</b>						
13a. STATE <b>Md.</b>			13b. COUNTY			13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>5107 Benton Hgts. Ave. 21206</b>			
14. FATHER'S NAME FIRST <b>Charles</b>			MIDDLE <b>B.</b>			LAST <b>Kirby</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Charlotte</b>			MIDDLE <b>A.</b>		LAST <b>Overby</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-24-4926</b>			17. INFORMANT <b>Charlotte Murphy, 605 Dwight Dr., Pasadena, Md.</b>			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						caused by			cardiogenic shock					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(b) <b>congestive heart failure</b>			DUE TO, OR AS A CONSEQUENCE OF			(c) <b>Diabetes, Ischemic heart disease</b>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost															
sow. the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.															
22b. SIGNATURE														22c. DATE SIGNED <b>2/11/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <b>7422 BALTIMORE-ANNAPOLIS BOULEVARD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
<b>BASANI K. KHANDELWAL, M.D.</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2-4-85</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Lakeview</b>			23d. LOCATION CITY OR TOWN <b>Carroll Co., Md.</b>			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1985</b>			25b. REGISTRAR'S SIGNATURE <b>John Ruck</b>									

RECORDED 07 1965 1142 AM

EDWARD KIRK CAGE

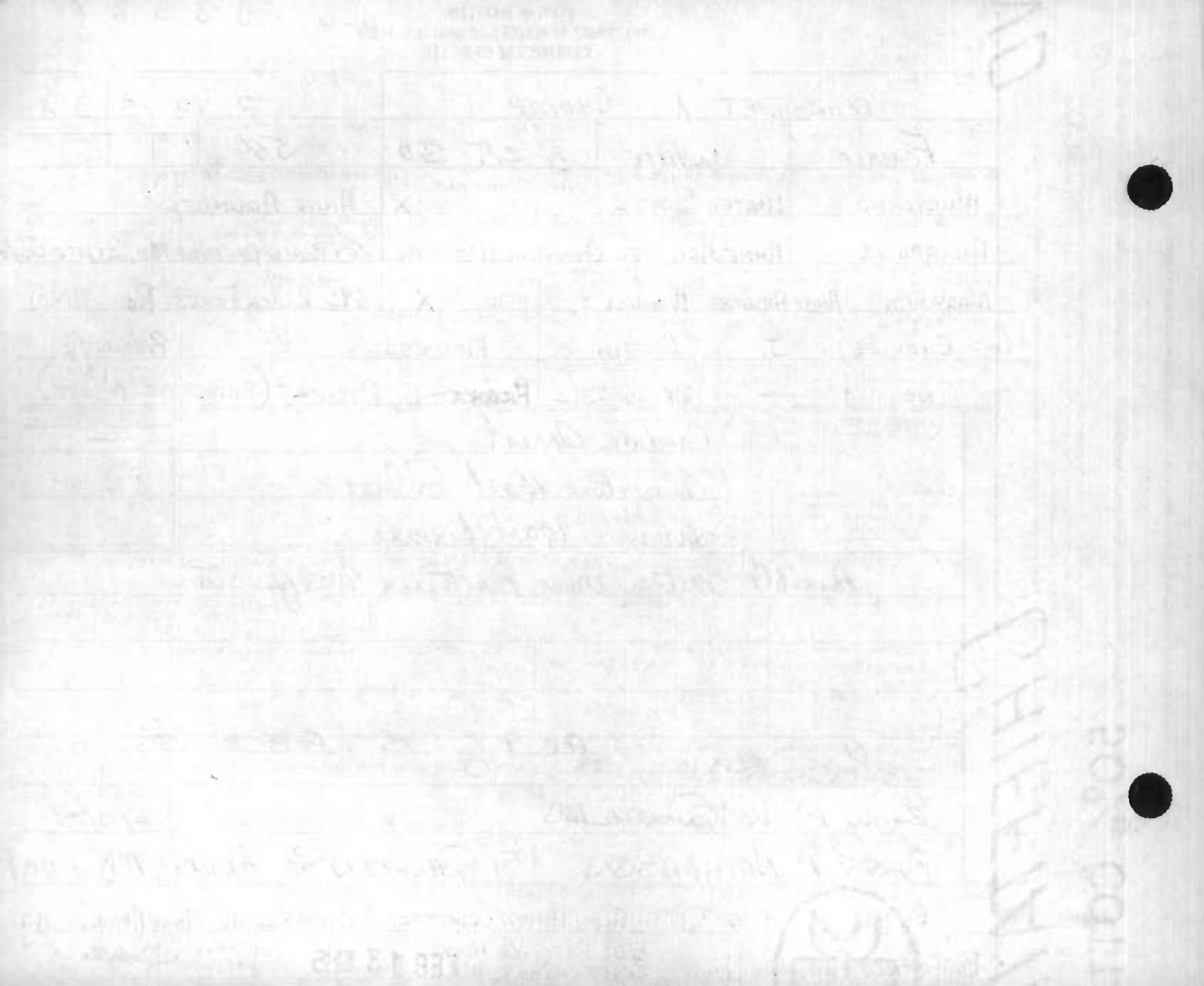
VINE AVENUE CHILLI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-troupe permit. Then photo remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 0334	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
MARGARET A CHANCE						2. DATE OF DEATH			2	10	85	3 A M	
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>5-25-30</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b>			MD.	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>KEY PUNCH OPERATOR</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>MD. STATE Govt.</b>				
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>Anne Arundel</b>			13c. CITY OR TOWN <b>Annapolis</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>696 Black Forest Rd. 21401</b>	
14. FATHER'S NAME FIRST <b>CHARLES</b>			MIDDLE <b>J.</b>			LAST <b>COFFIN</b>			15. MOTHER'S MAIDEN NAME FIRST <b>FRANCES</b>			LAST <b>RENNER</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>318-26-2392</b>			17. INFORMANT <b>ROBERT E. CHANCE (SAME AS ABOVE)</b>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>—</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>													
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b>												1 mo	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Ischemic Heart Disease</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>Bicuspid mitral valve prosthesis malfunction</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>FEB 9 1985</b> to <b>FEB 10 1985</b> , that (I) (we) last saw the deceased alive on <b>FEB 10 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.												22c. DATE SIGNED <b>2/10/85</b>	
22b. SIGNATURE <b>BARRY R. NATHANSON MD</b>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARRY R. NATHANSON</b>			22e. ADDRESS <b>51 FRANKLIN St. ANNAPOLIS, MD 21401</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>FEB 13, 1985</b>			23c. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN CEMETERY</b>			23d. LOCATION CITY OR TOWN <b>GLEN BURNIE ANNE ARUNDEL MD.</b>				
24. FUNERAL DIRECTOR NAME <b>BARRANCO FUNERAL HOME</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 13 1985</b>			25b. REGISTRAR'S SIGNATURE <b>JULIA DAVIDSON RONDELL</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

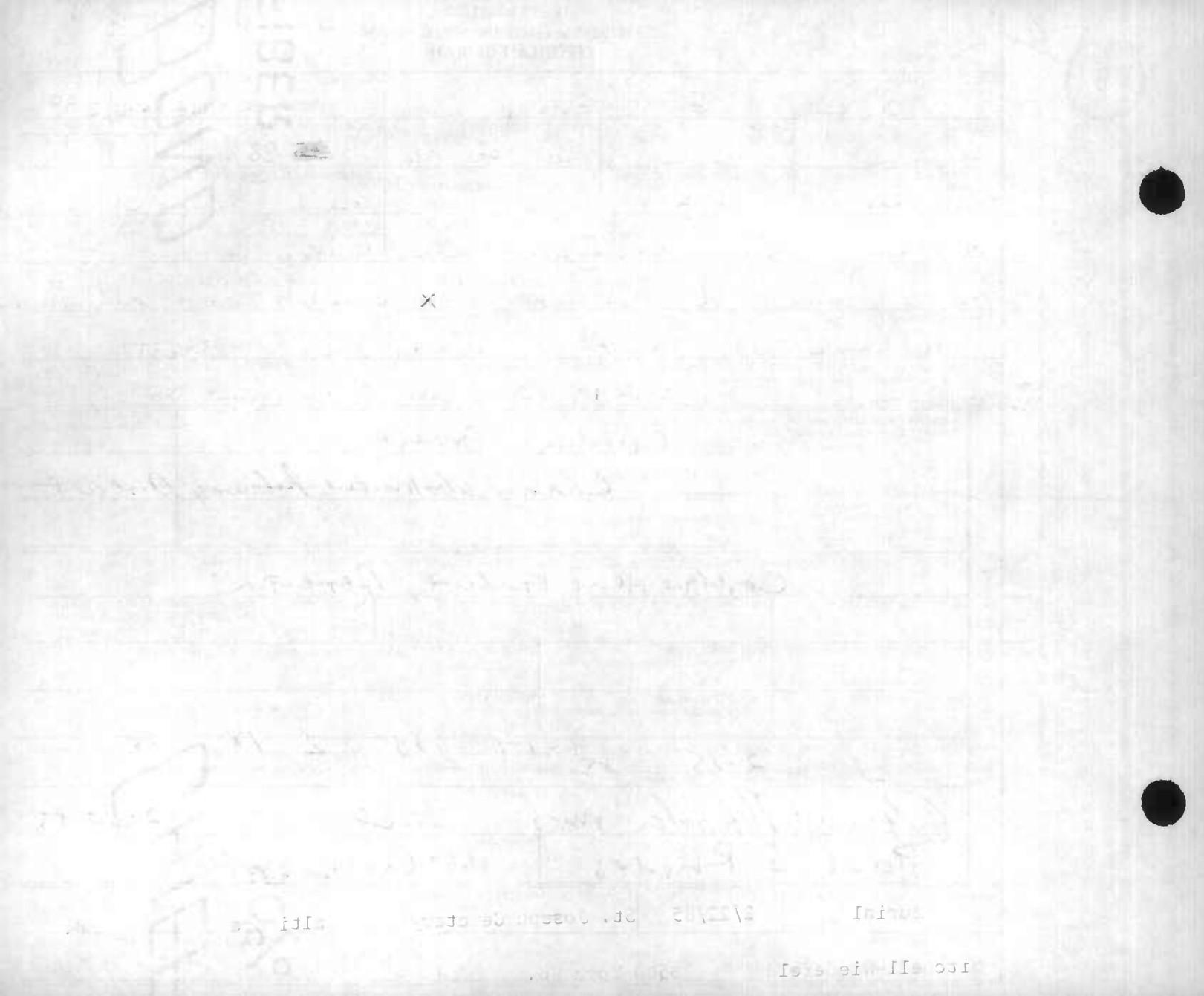
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 03348

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Alice</i>	MIDDLE <i>G. Chaney</i>	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR 2 18 85 3:55 M	
3. SEX <i>Female</i>		4. RACE <i>white</i>	5. DATE OF BIRTH MONTH DAY YEAR 10 26 96			6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel Co. MD.</i>	
10. CITY OR TOWN OF DEATH <i>Crofton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Crofton Convalescent Center</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md</i>		13b. COUNTY <i>Anne Arundel</i>	13c. CITY OR TOWN <i>Crofton</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>2043 Late Grove Court 21114</i>	
14. FATHER'S NAME FIRST <i>Nicholas</i>		MIDDLE <i>Frank</i>	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>Raney</i>			MIDDLE LAST <i>Scott</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Unknown</i>		16b. SOCIAL SECURITY NO. <i>213-68-1883</i>			17. INFORMANT ADDRESS <i>2043 Late Grove Court Crofton Md</i>			
18. CAUSE OF DEATH (Enter) only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Obstructive Pulmonary Disease</i> (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Congestive Heart Failure; Dementia</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>9-19 1985</i> to <i>2 18 1985</i> , that (I) (we) lost saw the deceased alive on <i>2-15 1985</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) (did not) view the body after death.								
22b. SIGNATURE <i>Paul J Rhodes Mrs</i>		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>2-18-85</i>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Paul J Rhodes</i>		22f. ADDRESS <i>1667 Crofton Center</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/22/85</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Joseph Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Baltimore</i>	COUNTY	STATE <i>Md.</i>
24. FUNERAL DIRECTOR NAME <i>Mitchell-Wiedefeld</i>		25a. ADDRESS <i>6500 York Rd.</i>			25b. DATE REC'D. BY REGISTRAR <i>FEB 20 1985</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 5 0 3 3 4 9						
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OF PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR			
			Elvira B Chaney						2 6 85						8:45 PM			
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female			white			MONTH 12 DAY 9 YEAR 95			89 YRS			MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Anne Arundel									
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY									
Annapolis			Anne Arundel General Hospital			Homemaker			Name									
13a STATE			13b COUNTY			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE			21401						
MD			A.A.			CITY OR TOWN Annapolis			K16 Giddings Avenue									
14 FATHER'S NAME			MIDDLE LAST			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO.			17 INFORMANT		ADDRESS 452 Broadwater Rd	
Irving			H. Boone			Elizabeth			216-32-1670D			Eleanor B. Straw-Arnold, MD 21012					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			Respiratory failure			DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia			10 days									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						(c) COPD											year	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <del>COPD</del> Hypertension, m																		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
21g. I certify that (I) this hospital attended the deceased from <u>Feb 3, 1985</u> , 19 <u>85</u> , to <u>Feb 6, 1985</u> , that (I) (we) lost			now, the deceased alive on <u>19 85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.															
21h. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22e. DATE SIGNED						
22a. PHYSICIAN'S NAME, TITLE OR OFFICE			22b. ADDRESS															
Wm. C. Weintraub, M.D.			Riva Road Annapolis, MD 21401															
23a. BURIAL, CREMATION, REMOVAL (CITY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN									
Burial			Feb. 9, 1985			Cedar Bluff			Annapolis									
24 FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Taylor Funeral Chapel-Annapolis, MD						FEB 8 1985			John Davidson Pendell									

February 20th 1901  
and continued until 21st  
and 22nd and 23rd  
and 24th and 25th  
and 26th and 27th  
and 28th and 29th  
and 30th and 31st

and 1st and 2nd and 3rd  
and 4th and 5th and 6th  
and 7th and 8th and 9th  
and 10th and 11th and 12th  
and 13th and 14th and 15th  
and 16th and 17th and 18th  
and 19th and 20th and 21st  
and 22nd and 23rd and 24th  
and 25th and 26th and 27th  
and 28th and 29th and 30th  
and 31st

and 1st and 2nd and 3rd  
and 4th and 5th and 6th  
and 7th and 8th and 9th  
and 10th and 11th and 12th  
and 13th and 14th and 15th  
and 16th and 17th and 18th  
and 19th and 20th and 21st  
and 22nd and 23rd and 24th  
and 25th and 26th and 27th  
and 28th and 29th and 30th  
and 31st

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be informed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												EST			
												REG. NO. _____			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST VIOLA			MIDDLE			LAST CHRISTMAN			FEBRUARY 26, 1985 PM			
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			M			
7b. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY			IF UNDER 1 YEAR MONTHS DAYS			
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NORTH ANNE ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Domestic			MD.			
13a. STATE Maryland			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4938 Pennington Avenue, 21226			
14. FATHER'S NAME FIRST Unknown			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST Valeria			MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			Md. 21225			
no			216-12-5340			Charlotte Burns			402 Fifth Ave., Balto.,						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO GENIC SHOCK												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. CEREBROVASCULAR ACCIDENT															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 2/26/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURYA P. MUNDRA, M.D.			22e. ADDRESS 203 E. PATAPSCO AVENUE BALTIMORE, MARYLAND 21225												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/1/1985			23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Pk.			23d. LOCATION CITY OR TOWN Glen Burnie, A. A. Co., Md.						
24. FUNERAL DIRECTOR NAME McCully Funeral Homes			25a. DATE REC'D. BY REGISTRAR MAR 1 1985			25b. REGISTRAR'S SIGNATURE Lie. Davidson Rendell									
Balto. Md., 21225 237 E. Patapsco Ave.															

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

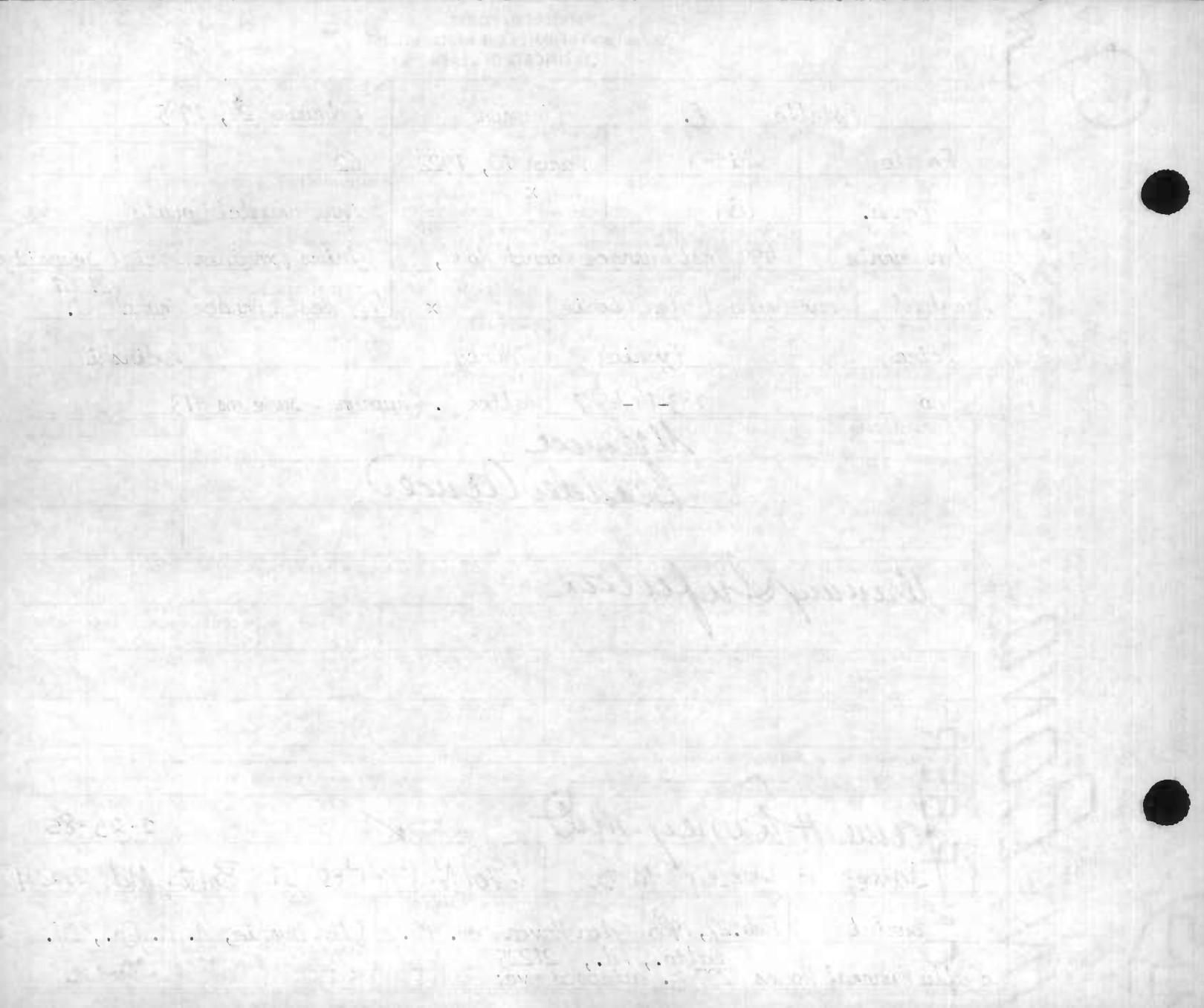
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 &amp; 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must sign this certificate.

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 5 0 3 3 5

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
<i>Estelle E. Chuprun</i>						<i>February 24, 1985</i>					
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
<i>Female</i>		<i>White</i>	MONTH	DAY	YEAR	<i>62</i>	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
<i>Penna.</i>		<i>USA</i>				<i>Anne Arundel County</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<i>Glen Burnie</i>		<i>499 West Furnace Branch Road,</i>			<i>Claims Examiner</i>			<i>Social Security</i>			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13c. STREET ADDRESS, ZIP CODE					
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Anne Arundel</i>	13c. CITY OR TOWN <i>Glen Burnie</i>			21061					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
<i>Peter</i>			<i>Evanick</i>	<i>Nancy</i>					<i>Podinski</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			
<i>no</i>		<i>183-14-4587</i>			<i>Walter J. Chuprun</i>			<i>Same as #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for Part I, II, and III) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Meningo</i> <i>Bleeding Cancer</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bleeding Cancer</i>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Urinary Infection</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											22c. DATE SIGNED <i>2-25-85</i>
22b. SIGNATURE <i>James H. Dorsey, M.D.</i>		22d. DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James H. Dorsey, M.D.</i>		22f. ADDRESS <i>6701 N. Charles St., Balt., Md. 21204</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Feb. 27, 1985</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Mem. Pk.</i>			23d. LOCATION CITY OR TOWN <i>Glen Burnie, A. A. Co., Md.</i>				
24. FUNERAL DIRECTOR <i>Baltimore, Md., 21225</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 25 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Lia Davidson Pendell</i>						
<i>McCully Funeral Homes</i>		<i>237 E. Patapsco Ave.</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner should be notified alone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												6 5 0 3 3 5 4																	
												REG. NO.																	
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR									
			KAY			S			Church						2-1-85				5 PM	5 PM									
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?		9. DATE OF DEATH			10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		
Female			White			MONTH DAY YEAR			47 YRS			RHODE ISLAND			USA		3-26-37			Annapolis		Anne Arundel General Hospital			SECRETARY GODDARD SPACE CENTER		MD.		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		14b. SOCIAL SECURITY NO.			14c. INFORMANT		14d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
MARYLAND			ANNE ARUNDEL			ODENTON			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1345 Farrara Drive			YES		038-24-2722			SYLVIA V. KENDER		7804 HANOVER PARKWAY GREENBELT, MD. 20770							
14e. FATHER'S NAME			14f. MIDDLE			14g. LAST			14h. MOTHER'S MAIDEN NAME			14i. FIRST			14j. MIDDLE			14k. LAST											
WILLIAM						CHURCH			ANNA LAPORTE																				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pontine Stroke</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Malignant Brain Tumor</i>																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																				
1/31/85			<i>Brain Tumor (Malignant)</i>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21e. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>																													
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 29</i> , 19 <i>85</i> , to <i>Feb 1</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>Feb 1</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED																	
22b. SIGNATURE <i>Thomas B. Parker, M.D.</i>												DEGREE																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																	
22e. ADDRESS																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIY			23d. LOCATION CITY OR TOWN			COUNTRY			STATE														
BURIAL			2-5-85			OAK GROVE CEMETERY			ASHAWAY			WASHINGTON			R.I.														
24 FUNERAL DIRECTOR ROBERT E. EVANS 1212 WEST. STREET ADDRESS ANNAPOLIS, MD. 21401												25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Pendall</i>															
DHMH - 16 60M 7/84 (VRA 15, 4)																													



2021.03

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH FORM PM 4. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 0 3 3 5 3		
1- STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 2/ 15/ 85 M	2b. HOUR 24 HOUR 11:09 AM	
1. DECEASED NAME (TYPE OR PRINT)			Sandra			Lee			Clark			2c. DATE PRONOUNCED DEAD 2/ 15/ 85 A	2d. MONTH DAY YEAR	
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN							9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.		
Female	White	7 28 41	43 yrs.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Homemaker					
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1711 Leisure Lane 21061						
14. FATHER'S NAME FIRST Byron			MIDDLE Safford			15. MOTHER'S MAIDEN NAME FIRST Verna			LAST Gardner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. No 224-54-5823			17. INFORMANT James R. Clark Sr.			ADDRESS Glen Burnie, Md. 21061					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF  { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						TITLE (SPECIFY) M.D. Dennis F. Smyth, M.D. Assistant			MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)			Dennis F. Smyth, M.D.			ADDRESS 111 Penn St.						DATE SIGNED 2/16/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-19-85			23c. NAME OF CEMETERY OR CREMATORIUM Crownsville Cemetery			23d. LOCATION CITY OR TOWN Crownsville			COUNTY A.A. Md.	STATE	
24. FUNERAL DIRECTOR NAME Raymond C. Fink			ADDRESS Glen Burnie, Md. 21061			25a. DATE REC'D. BY REGISTRAR FEB 15 1985			25b. REGISTRAR'S SIGNATURE Julie Davidson					
(VR A15 ME (5))														

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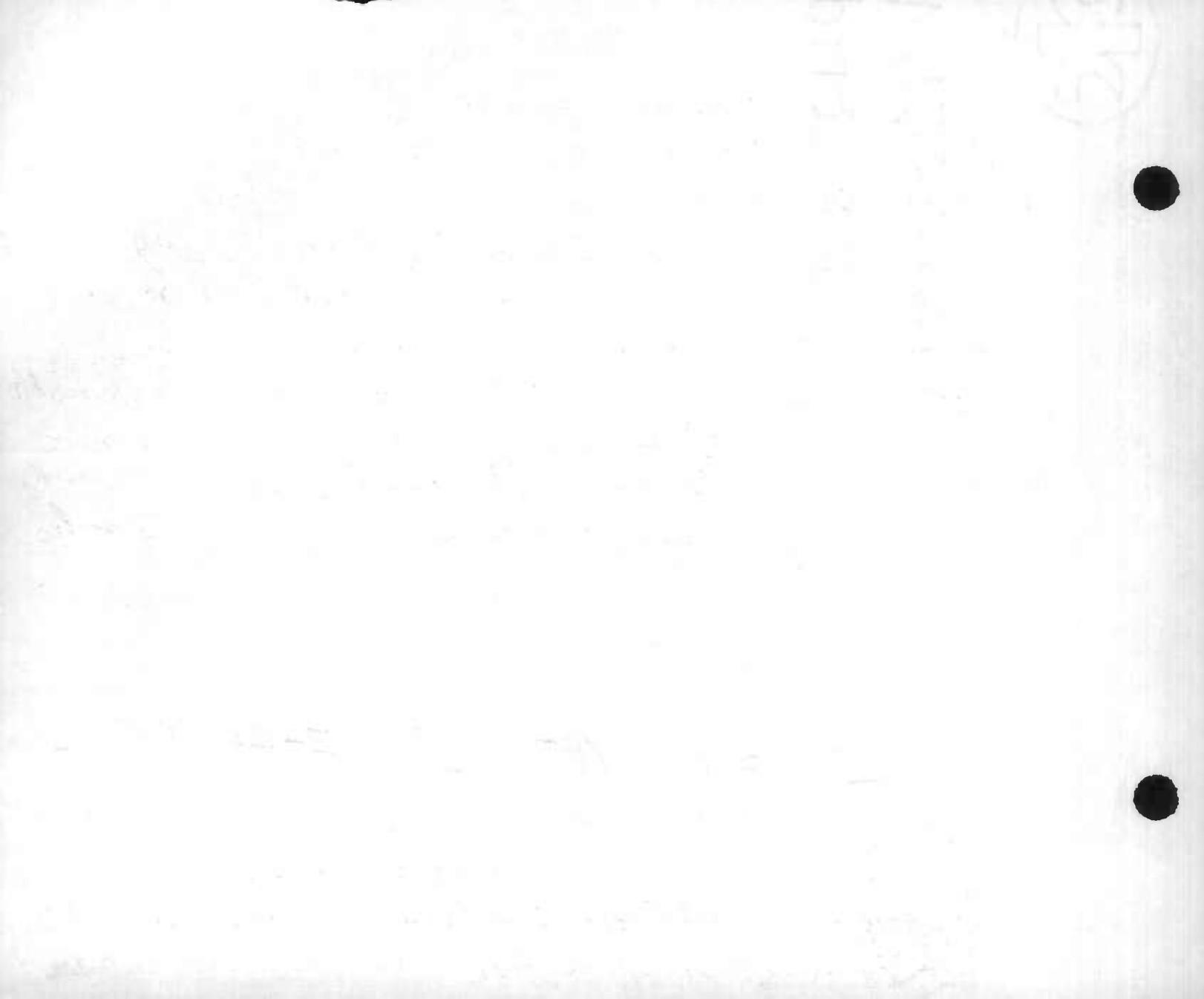
11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified and informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												03354			
REG. NO.															
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			GORDON Haney			CLAUDE			2 - 20 85			5:28 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
MALE		WHITE		APR 22 1935			49								
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Annapolis Md		U.S.A.					Anne Arundel								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis		Anne Arundel General Hosp			PRINTER			AA. Co. Govt							
13a. STATE MD.		13b. COUNTY AA-		13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1100 East St.		ZIP CODE 21401				
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			LAST								
William T.		Claude		Grace Josephine Artz											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT W.M.T. Claude 2 Arnold Re Arnold Md									21012		
YES		KOREA		213-32-1853									6 mo -		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												6 mo -			
(b) Bronchopneumol Fistula 2-cwh															
(c) Emphysema												2 weeks			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from 10-1 1985 to 2-20 1985, that (I) ( ) last saw the deceased alive on 2-17 1985, and that in (my) ( ) opinion death occurred on the date and hour and from the causes stated above, (I) ( ) did not view the body after death.															
22b. SIGNATURE Dr. Michael J. Richardson, MD		22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 2/20/85							
22e. PHYSICIAN'S NAME (TYPE OR PRINT)					22f. ADDRESS Annapolis Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 02-11-85		23c. NAME OF CEMETERY OR CREMATORIAL GEAR HILL Crem.			23d. LOCATION CITY OR TOWN Suitland			COUNTY PG. Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR FEB 21 1985			25b. REGISTRAR'S SIGNATURE Michael Richardson							
Taylor Funeral Chapel Annapolis Md.															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Box 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene either to burial or removal.

IMPORTANT: If item 21 is marked on Item 18, show any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												03355	
												REG. NO. EST	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
ROSIE			A.	COATES		FEBRUARY 26, 1985						8:15 A.M.	
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female			Negro	MONTH	DAY	YEAR	79			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			U.S.A.						ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
GLEN BURNIE			NORTH ARUNDEL HOSPITAL										
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland			AnneArundel		Severn					1771 Circle Road 21144			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST			
Steven					Harris	Emma							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS				
NO			214-22-5170			Madeline Levrone			1771 Circle Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cva</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>atherosclerosis</i>													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> <i>not while at work</i>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) this hospital attended the deceased from <i>2/25/85</i> to <i>2/15/85</i> , 19													
now the deceased alive on <i>2/25/85</i> 19													
above, (I) did not view the body after death.													
22b. I certify that (I) (we) last saw the deceased alive on <i>2/25/85</i> 19													
22c. SIGNATURE			DEGREE			22e. ADDRESS			22f. DATE SIGNED				
<i>George B. Ramirez M.D.</i>						7845 OAKWOOD ROAD, #205 GLEN BURNIE, MARYLAND 21061			<i>2/26/85</i>				
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 3/2/85			23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery			23d. LOCATION Anne Arundel Co., MD.				
24. FUNERAL DIRECTOR Wm C March F/H, Inc. 1101 E North Ave						25a. DATE REC'D. BY REGISTRAR FEB 27 1985			25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>				

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FEDERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be deposited for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03356	EST		
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		FEBRUARY 16, 1985			1120 PM		
LORA			WANNETTA COBNER										
3. SEX female			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR		6. AGE IN YEARS LAST BIRTHDAY			# UNDER 1 YEAR		
						Sept 9, 1932 <sup>8</sup>		54			MONTHS DAYS		
7a. BIRTHPLACE COUNTRY W. Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY			# UNDER 24 HRS		
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF NOT IN HOSPITAL FACILITY GIVE STREET ADDRESS NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) secretary		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse					
13a. STATE MD			13b. COUNTY AA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1316 Tarrant Rd			21061		
14. FATHER'S NAME Daniel W.			MIDDLE L.			15. MOTHER'S MAIDEN NAME Sarah		MIDDLE I.			Johnson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO			16b. SOCIAL SECURITY NO. XXXXXX 218/30/5555			17. INFORMANT Kathie Murphy (daughter)		ADDRESS Brooklyn Park, MD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST													
DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above. (I) (we) (did) (did not) view the body after death													
22b. SIGNATURE <i>Michael Schwartz M.D.</i> DEGREE													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL SCHWARTZ M.D.			22e. ADDRESS 606 HAMMONDS LANE BALTIMORE, MARYLAND 21225					22f. DATE SIGNED 2-18-84					
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 20 Feb. 1985			23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem Pk			23d. LOCATION Glen Burnie AA			MD STATE	
24 FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, MD			25a. DATE REC'D. BY REGISTRAR FEB 19 1985					25b. REGISTRAR'S SIGNATURE L. Hudson-Pendleton					

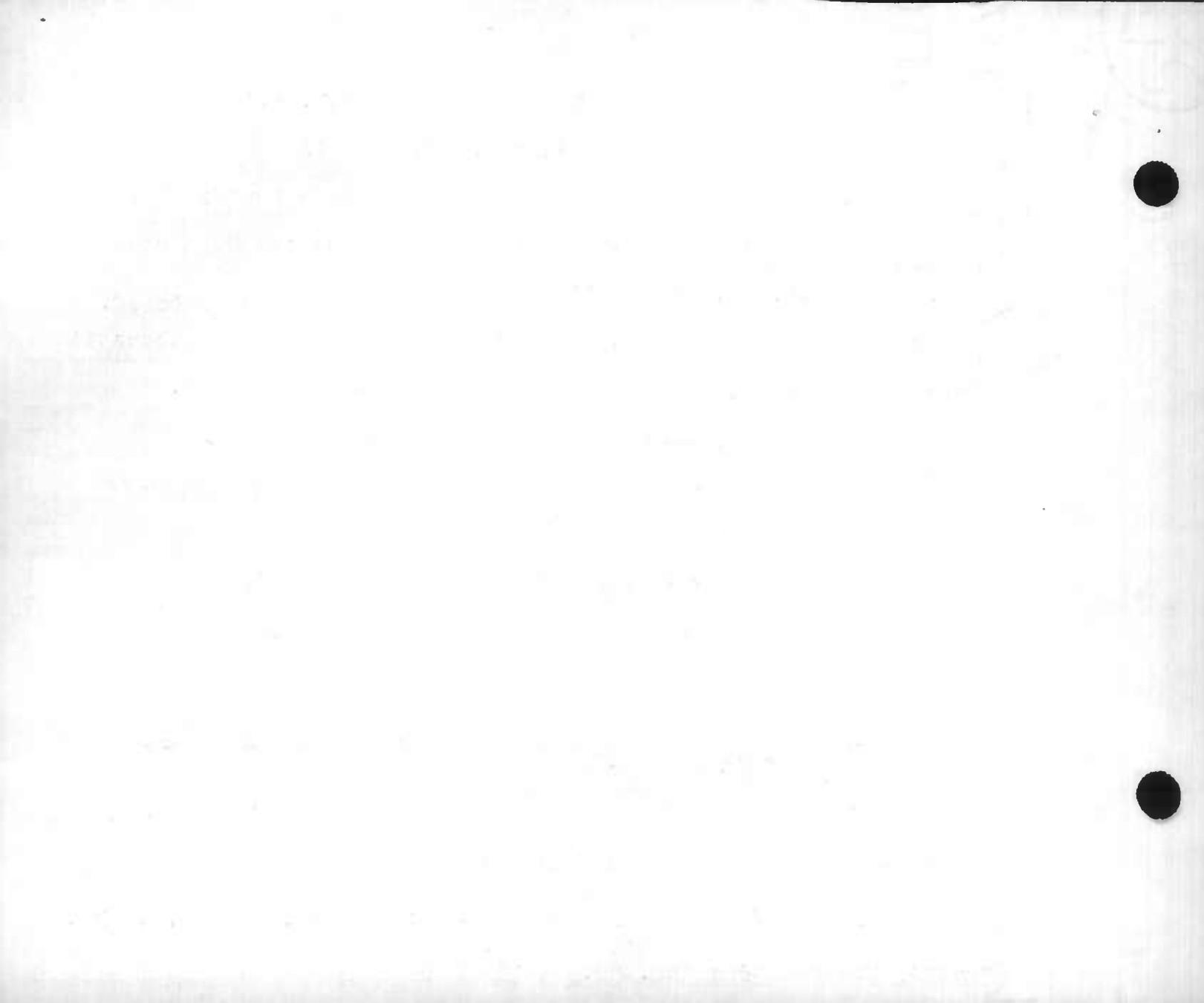


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please execute within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03357					
1. DECEASED NAME (TYPE OR PRINT)			FIRST Jack	MIDDLE Cohen	LAST	2a. DATE OF DEATH		MONTH Feb.	DAY 4, 1985	YEAR	2b. HOUR				
3. SEX male			4. RACE white			5. DATE OF BIRTH MONTH June DAY 8, 1898 YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS MONTHS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minsk, Russia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co.			MD.			
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 620 Best Gate Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant			12b. KIND OF BUSINESS OR INDUSTRY Retail sales						
13a. STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 620 Best Gate Rd.		21401					
14. FATHER'S NAME FIRST Meyer			15. MOTHER'S MAIDEN NAME FIRST Esther			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW I 219-32-1205			17. INFORMANT ADDRESS Sidney Cohen same as 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>chronic congestive heart failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>atherosclerotic cardiovascular disease</i> (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>unstable heart infection, occlusive ulcers</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>1-6</i> , 19 <i>84</i> , to <i>2-4</i> , 19 <i>85</i> , that (we) last saw the deceased alive on <i>2-15</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (I) (we) view the body after death.															
22b. SIGNATURE <i>Gregory A. Mitchell MD</i>										22c. DEGREE DEGREE					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gregory A. Mitchell MD</i>										22e. ADDRESS <i>205 Ridgeley Ave. Md. 21401</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/5/85			23c. NAME OF CEMETERY OR CREMATORIAL Kneseth Israel Cem.			23d. LOCATION CITY OR TOWN Ann.			COUNTY A.A. Md.		STATE	
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home Ann. Md. 21401										25a. DATE REC'D. BY REGISTRAR FEB 8 1985		25b. REGISTRAR'S SIGNATURE <i>Jolie Davidson-Pendell</i>			



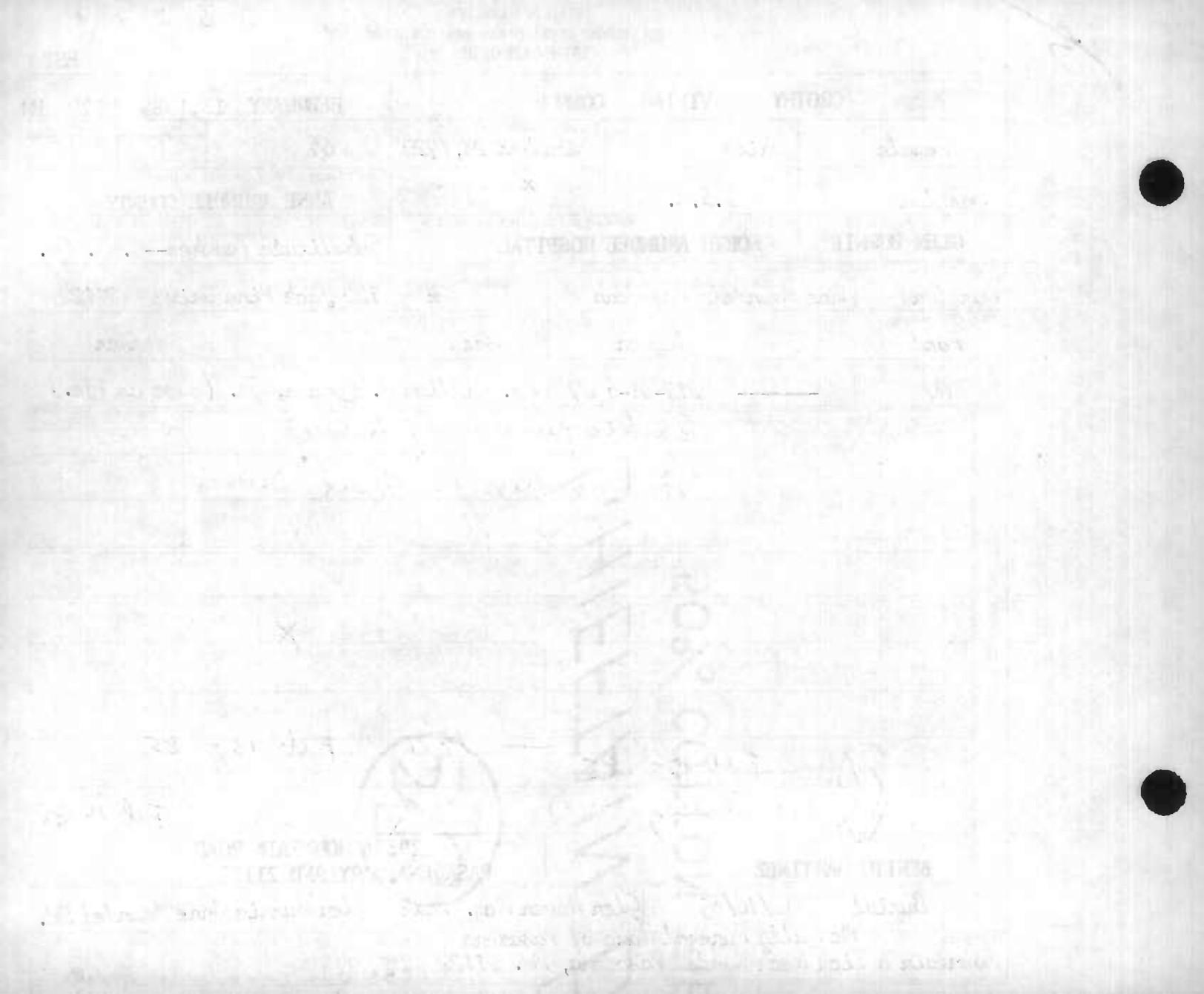
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial/transit permit. Then please remove cord/paper. Pages 1 & 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 22 shows any injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. EST				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	FEBRUARY 13, 1985							929 AM	
3. SEX <i>Female</i>			4 RACE <i>White</i>	5. DATE OF BIRTH <i>Month December Day 28, 1920</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i>			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County MD.</i>					
10. CITY OR TOWN OF DEATH <i>GLEN BURNIE</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY AS GIVING STREET ADDRESS) <i>NORTH ARUNDEL HOSPITAL</i>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Substitute Teacher - A. A. Co.</i>				
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Pasadena</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET, ADDRESS, ZIP CODE <i>120 Jack Pine Drive 21122</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>A. A. Co.</i>			
14. FATHER'S NAME <i>Ford</i>			FIRST	MIDDLE	LAST <i>Hayden</i>	15. MOTHER'S MAIDEN NAME <i>Mary Werner</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>217-01-6327</i>			17. INFORMANT <i>Mr. William H. Connor, Jr. (same as 13e.)</i>			ADDRESS					
18. CAUSE OF DEATH: Enter only one cause per line. (a) (b) (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac pulmonary arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (we) (hospital) attended the deceased from saw the deceased alive on <i>Feb 12- 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (hospital) did not view the body after death.										<i>1976 to Feb 13- 1985</i>				
22b. SIGNATURE <i>Guaranteed in 10</i>										22c. DATE SIGNED <i>Feb 14-85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BENITO MARTINEZ</i>			22e. ADDRESS <i>2932A MOUNTAIN ROAD PASADENA, MARYLAND 21122</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2/16/85</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Glen Haven Mem. Park</i>			23d. LOCATION <i>Glen Burnie Anne Arundel Md.</i>					
24. FUNERAL DIRECTOR NAME <i>McCullly Funeral Home of Pasadena Mountain &amp; Tick Neck Roads Pasadena, Md. 21122</i>			25a. DATE REC'D. BY REGISTRAR <i>FEB 19 1985</i>							25b. REGISTRAR'S SIGNATURE <i>Susan Anderson</i>				
BP														
DHMH - 16 50M 4/B3 (VRA 15, 4)														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 03359						
										REG. NO.						
1 - FOR STATE REGISTRAR			I DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			Myrtle Ivy Cooper						Feb. 8, 1985						10 35 AM	
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			Caucasian			June 4, 1891			93			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
New York			US			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Anne Arundel							
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Crofton			Crofton Convalescent Center						Home maker							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland			Anne Arundel			Millersville			x			1301 Shawnee Court 21108				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
William Harder			Nancy Stillwell													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
no			124-22-2947			Marilyn M. Houston			same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to, or as a consequence of (c) Due to, or as a consequence of										x						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										2 years						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 28 Sept 19 85 to 31 Jan 19 85, that (I) (we) last saw the deceased alive on 8 Feb 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						326 Lynwood Dr Severs Park										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE			
Burial			May 1985			Oakwood Cemetery			Theresa Jefferson							
24. FUNERAL DIRECTOR NAME			16000 Annapolis Road			ADDRESS			FEB 11 1985			REG. NO.				
Beall Funeral Home			owie, Maryland													
25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE						

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order, 10 cents

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or

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1900, 10 cents

va

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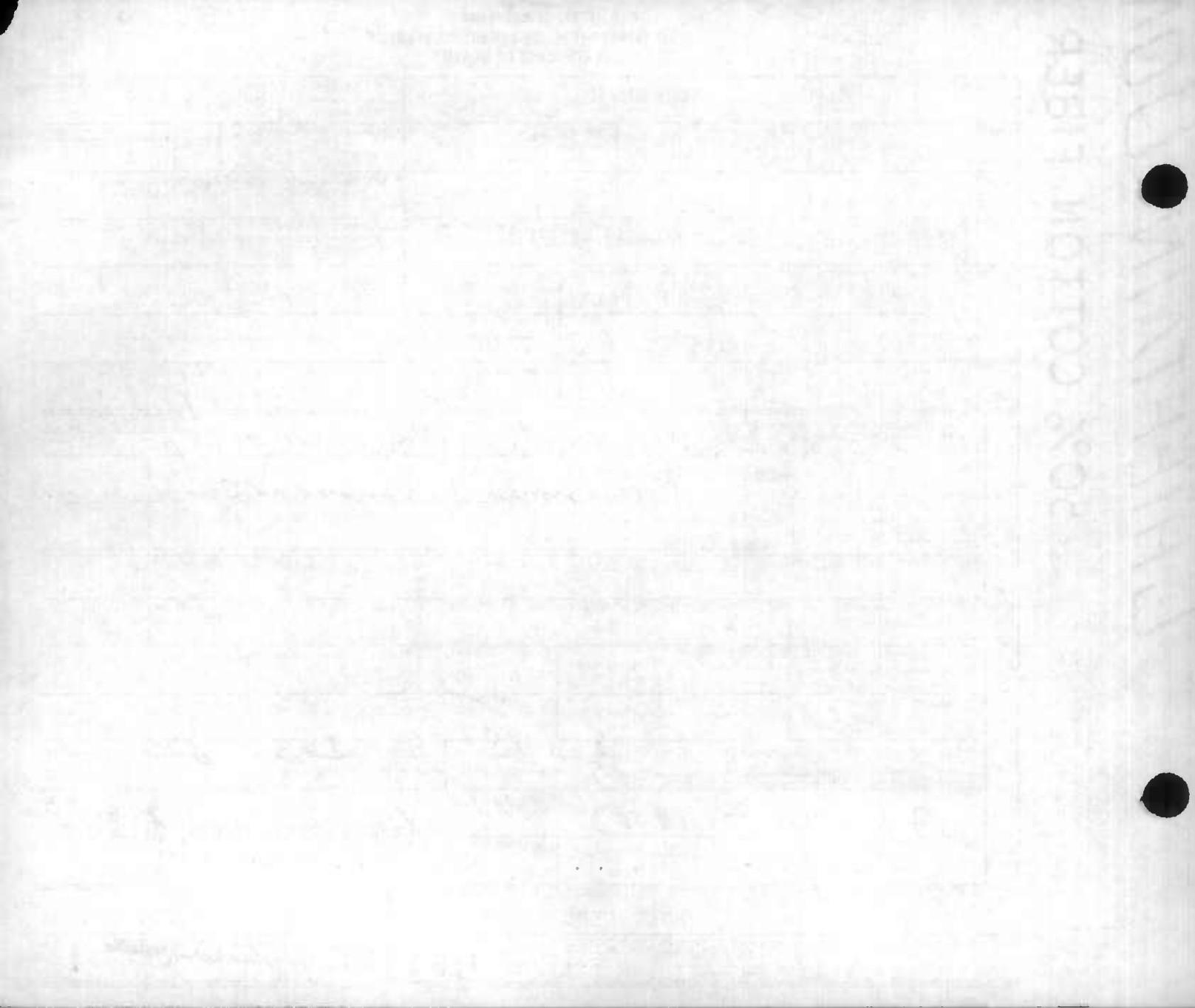
order

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3503360	EST
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST CLEO	MIDDLE PAULINE	LAST COX	20. DATE OF DEATH MONTH DAY YEAR			26 HOUR				
3. SEX FEMALE			4. RACE CAUCASIAN			5. DATE OF BIRTH MONTH 8 DAY 9 YEAR 08			6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION (IF NOT HOME, GIVE STREET ADDRESS) NORTH ANNE ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MARYLAND			13b. COUNTY ANNE ARUNDEL			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 701 GLENWOOD ST. 21401				
14. FATHER'S NAME ALEX			MIDDLE HARRIS			15. MOTHER'S MAIDEN NAME ESTAX			MIDDLE CROOKSHANKS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 579-42-4724			17. INFORMANT SHARON K. RILL			8800 BEECHTREE RD. SEVERN, MD 21114				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis (Pneumococcal) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia (Pneumococcal) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2-3-85, 1985, to 2-5-85, 1985, that (I) (we) last saw the deceased alive on 2-3-85, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 2-6-85	
22b. SIGNATURE A. Shams Jr. 110			22c. DEGREE M.D.			ATTENDING PHYSICIAN			MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDULLAH SHAMS PIRZADEH, M.D.			22e. ADDRESS 1333 (ROUTE 1) DRIVE, SUITE 105			GLEN BURNIE, MARYLAND 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2-9-85			23c. NAME OF CEMETERY OR CREMATORIES FORT LINCOLN CEMETERY			23d. LOCATION BRENTWOOD P.G.CO. MD.				
24. FUNERAL DIRECTOR NAME ROBERT E. EVANS ANNAPOLIS, MARYLAND			1212 WEST STREET ADDRESS			25a. DATE REC'D. BY REGISTRAR FEB 14 1985			25b. REGISTRAR'S SIGNATURE Julie Davidson-Pender				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 85 03361					
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR					
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		Feb 16 1985			6:45pm				
Edward G. Cox Sr.															
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS					
Male		White		Jan 21 1936			49			IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Annapolis Md.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Anne Arundel Co.								
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
ANNAPOLIS		ANNE ARUNDEL GENERAL HOSP.							CONTRACTOR						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE					
13d. STATE MD.		13b. COUNTY A.A.C.O.		13c. CITY OR TOWN DAVIDSONVILLE			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			21035					
14 FATHER'S NAME FIRST		MIDDLE		LAST			15 MOTHER'S MAIDEN NAME FIRST			MIDDLE					
Edward				Cox			Camilla			LAST					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT			18 ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
no		216-30-1283		Nancy S. Cox same as 13e.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										CHF - Delirious					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED							20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET				CITY OR TOWN		COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 1884, 19 to 4/16/85, 19, that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 2/16/85 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> did/did not view the body after death.										22c. DATE SIGNED 4/16/85					
22b. SIGNATURE John Hoffman for Robert O Biern										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4/16/85			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT O. BIERN MD SPWATKINS MD										22f. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE BURIAL 2/20/85			23c. NAME OF CEMETERY OR CREMATORIAL LAKEMONT CEMETERY			23d. LOCATION CITY OR TOWN DAVIDSONVILLE			COUNTY A.A. MD. STATE			
24 FUNERAL DIRECTOR NAME HARDESTY FUNERAL HOME			12 RIDGELY AVE. ANN.MD. 21401			25a. DATE REC'D. BY REGISTRAR FEB 20 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall						
DHMH - 16 60M 7/B4 (VRA 15, 4)															



SOCIETY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

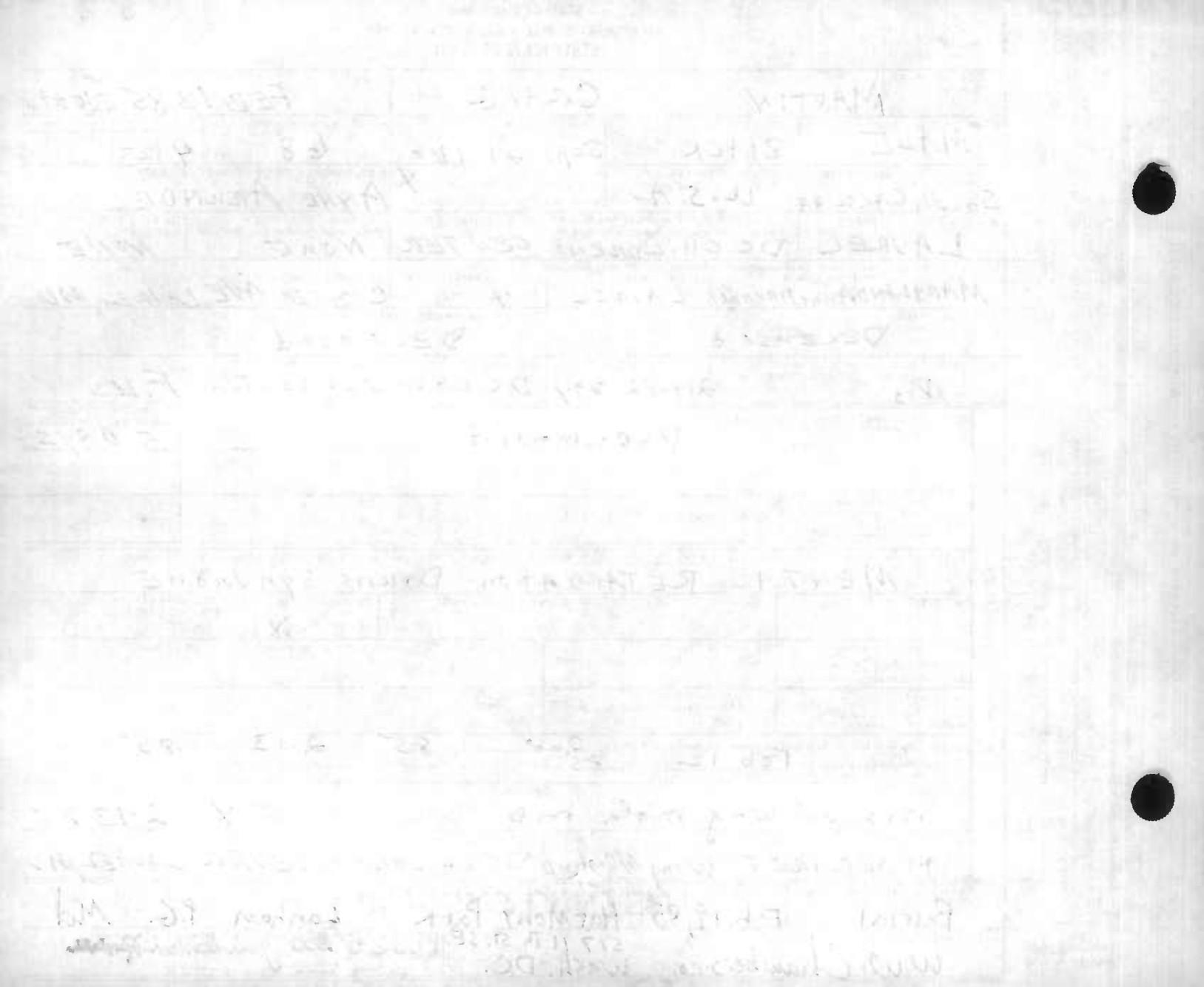
IMPORTANT: If item 21 is marked or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 5 0 3 3 6 2			
1 - STATE REGISTRAR			2R. DATE OF DEATH MONTH DAY YEAR FEB 13 85							2B. HOUR 3:00 P.M.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MARTIN	MIDDLE CRAIG	5. DATE OF BIRTH MONTH DAY YEAR Sept 21 1916			6. AGE (IN YEARS LAST BIRTHDAY) YRS. 68		IF UNDER 1 YEAR MONTHS 4		IF UNDER 24 HRS HOURS 23		
3 SEX MALE		4 RACE BLACK	7. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH AYNE ARNOLD MD.					
10. CITY OR TOWN OF DEATH LAUREL		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) D.C. CHILDREN'S CENTER					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None			12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. STATE MARYLAND		13b. COUNTY Anne Arundel		13c. CITY OR TOWN LAUREL			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS CENTER AVE, LAUREL MD 20707				
14. FATHER'S NAME DECEASED		15. MOTHER'S MAIDEN NAME DECEASED											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN) No		16b. SOCIAL SECURITY NO 214-82-0104			17. INFORMANT D.C. CHILDREN'S CENTER FILES		ADDRESS						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS			
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) MENTAL RETARDATION - Down's Syndrome													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from Feb 12 1985 to Feb 13 1985, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Margaret Wong Mola, M.D.										22c. DATE SIGNED 2-13-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARGARET Wong MOLA		22e. ADDRESS D.C. CHILDREN'S CENTER LAUREL MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 19, 85		23c. NAME OF CEMETERY OR CREMATORIAL Harmony Park			23d. LOCATION CITY OR TOWN Lanham		COUNTY Md.		STATE		
24. FUNERAL DIRECTOR NAME W.W. Chambers Co.		ADDRESS 517 11th St. S.E. wash. D.C.								25. REMARKS BY REGISTRAR, REGISTRAR'S SIGNATURE FEB 20 1985 John Davidson, Registrar			

BP \_\_\_\_\_

DHMH-16 25M  
(VRA 15, 4) 1/79



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Please return by the Hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8503363			
1 - FOR STATE REGISTRAR				REG. NO.											
1a DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH				MONTH	DAY	YEAR	2b HOUR			
		ROBERT	W.	CREMINS	2-17-85							11:00AM			
3 SEX		4 RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Male		Caucasian		May 27, 1922				62							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Washington, D.C.		United States						Anne Arundel County, MD.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Annapolis		Anne Arundel General Hospital				Co-Owner				Stamp & Coin					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE					
Maryland		Anne Arundel		Annapolis						1919 West Street / 21401					
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME				LAST						
		Timothy	M.	Cremins	Genevieve				Williamson						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT				ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Yes		II 579-18-1660		Mr. William J. Cremins, Brother				Box 4542, Sunriver, Oregon 97707				3 weeks			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i> (b) <i>Interventricular bleeding and hypovolemia</i> (c) <i>Shock</i>															
DUE TO, OR AS A CONSEQUENCE OF												2 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
19b.						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
		P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>2/1/85</i> to <i>2/17/85</i> , that (I) (we) last saw the deceased alive on <i>2/10/85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE <i>William J. Cirksena</i>		DEGREE <i>MD.</i>		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>2/17/85</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William J. Cirksena</i>		22e. ADDRESS 4905 Del Ray Avenue Bethesda, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE February 20, 1985		23c. NAME OF CEMETERY OR CREMATORIUM Parklawn Memorial Park		23d. LOCATION CITY OR TOWN Rockville		COUNTY		STATE Maryland					
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey P.A., Bethesda, Maryland		ADDRESS				25a. DATE REC'D. BY REGISTRAR FEB 21 1985		25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>							

28 812 100 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 7 should be held within 72 hours after death.

IMPORTANT: If Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 03364 EST
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>MARIE ESTELLE CROSBIE</b>				2a DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 10, 1985</b>				2b HOUR <b>1130 AM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 24, 1902</b>				6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>82</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION (IF NOT IN RESIDENCE, GIVE ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Inspector</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>MD. State</b>		
13a. STATE <b>MD.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>212 Third Ave. S.E. 21061</b>				
14. FATHER'S NAME FIRST <b>Arthur</b>		MIDDLE LAST <b>Justice</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ellem</b>				MIDDLE LAST <b>Thurn</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-28-5677</b>				17. INFORMANT		ADDRESS <b>Norine Fox 500 Riverside Dr. 21122</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>2/1/85</u> , to <u>2/10/85</u> , 1985, that (1) (we) lost saw the deceased alive on <u>2/10/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>2/10/85</u>
22b. SIGNATURE <u>Rani S. Karipineni</u>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RANI S. KARIPINENI, M.D.</b>		22e. ADDRESS <b>200 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>13 Feb. 85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>New Cathedral Cem.</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b>		COUNTY		STATE <b>Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley</b>		ADDRESS <b>421 Crain Hwy. Glen Burnie</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1985</b>		25b. REGISTRAR'S SIGNATURE <u>James S. Kirkley</u>				

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Item 15 per phone 2/20/85 dad STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03365

FOR  
 1- STATE  
 REGISTRAR

REG. NO.

1. DECEASED NAME  
 (TYPE OR PRINT)

FIRST

MIDDLE

LAST

Patrick Hugh Curlin

20. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2d HOUR
<input checked="" type="checkbox"/>	26	1985	1802	M

2. SEX

4. RACE

5. DATE OF BIRTH  
 MONTH DAY YEAR

6. AGE (IN YEARS  
 LAST BIRTHDAY)

IF UNDER 1 YR.  
 MONTHS DAYS

IF UNDER 24 HRS.  
 HOURS MIN.

2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR
<input type="checkbox"/>				19 M

Male White

July 5 1944 40 yrs.

YRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR  
 FOREIGN COUNTRY)

Florida

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED  
 WIDOWED

NEVER MARRIED  
 DIVORCED

XX

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel Co.

10. CITY OR TOWN OF DEATH

Annapolis

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
 (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

1204 E. Gemini Dr.

12a. USUAL OCCUPATION (TYPE OF WORK)

EXECUTIVE

12b. KIND OF BUSINESS  
 OR INDUSTRY

Communicat

13a. STATE

XFFF

13b. COUNTY

NY

13c. CITY OR TOWN

NY

13d. INSIDE CITY LIMITS?

YES

NO

13e. STREET ADDRESS

431 West 44th. St. Apt. #3A

14. FATHER'S NAME

FIRST

MIDDLE

LAST

James Clifford Curlin

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Mary

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)  
 (IF YES, GIVE WAR OR DATES)

Yes

Vietnam

16b. SOCIAL SECURITY NO.

497-46-7000

17. INFORMANT

MARY M. CURLIN

Same as #11

18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)).

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
 gave rise to immediate  
 cause (o) stating the under-  
 lying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
 BETWEEN ONSET AND DEATH

Pneumonia

Flu Syndrome

Part 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES  NO

21a. EXTERNAL CAUSE WAS

UNDERLYING  OR  
 CONTRIBUTING  CAUSE OF DEATH

21b. TIME OF INJURY  
 HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE  NOT WHILE   
 AT WORK  AT WORK

21e. PLACE OF INJURY (AT HOME,  
 STREET, FACTORY, FARM, ETC.)

21f. LOCATION  
 STREET

CITY OR TOWN

COUNTY STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy  Inspection  Inquiry  and in my opinion

death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
 SIGNATURE

William P. Jones, M.D. Deputy MEDICAL EXAMINER

DATE SIGNED 2/7/85

EXAMINER'S NAME  
 (TYPE OR PRINT)

William P. Jones, M.D.

ADDRESS 1095 American Ct. 21035

23a. BURIAL, CREMATION, REMOVAL  
 (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION  
 CITY OR TOWN

COUNTY STATE

Cremation

2-8-85

Balt.

Balt. Md.

24 FUNERAL DIRECTOR  
 NAME

Ann Arbor, Md.

Hardesty Funeral Home

12 Ridgely Ave.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Jane Davidson Pendell

RECORDED IN THE LIBRARY OF THE  
UNIVERSITY OF TORONTO LIBRARIES 2002

various  
parts of

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in winter, in forest (and) -

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file it in the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 03360

1. DECEASED NAME (TYPE OR PRINT)	FIRST Winnie	MIDDLE Cutler	LAST Davidson	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR <u>12</u>
2. SEX Female	4 RACE White	5. DATE OF BIRTH MONTH <u>Apr.</u> DAY <u>15</u> YEAR <u>1890</u>	6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>	# UNDER 24 HRS. HOURS <u>0</u> MIN. <u>0</u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Ann Arundel MD.		
10. CITY OR TOWN OF DEATH Crofton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Convalescent Nursing Home			12a. USUAL OCCUPATION Secretary	12b. KIND OF BUSINESS OR INDUSTRY Private Business
13a. STATE Washington D.C.	13b. COUNTY Washington	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2121--16th St., BN.W. 20009	
14. FATHER'S NAME FIRST John	MIDDLE	LAST Davis	15. MOTHER'S MAIDEN NAME FIRST Sarah	MIDDLE J.	LAST Mooney
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 578-46-1196	17. INFORMANT ADDRESS Edgewater, Md.	Jean E Crickenberger. 224 Riverside Rd.,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio - Respiratory arrest</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Microscopic Cardi - Vasculitis</i> yes.		
			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congestive heart failure</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Chronic Obstructive Pulmonary Disease - Right heart failure due to Pneumonia</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) this hospital attended the deceased from Jan 8, 1985, to Feb 19, 1985, that (we) lost saw the deceased alive on above date (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>BARRY R. NATHANSON, MD</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2/19/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BARRY R. NATHANSON</i>	22e. ADDRESS 51 Franklin St Annapolis, MD 21401				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/22/1985	23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemetery	23d. LOCATION CITY OR TOWN Washington, D.C.	23e. COUNTY	23f. STATE
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.			25a. DATE REC'D. BY REGISTRAR FEB 26 1985	25b. REGISTRAR'S SIGNATURE <i>Sylvia Leinwand-Randall</i>	

*positive*      *negative*

• [View Details](#) • [Edit Details](#) • [Delete](#)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												EST				
1 - STATE REGISTRAR			REG. NO. 03361													
1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>AMANDA</b>	MIDDLE <b>ELLEN</b>	LAST <b>DAVIS</b>	2a. DATE OF DEATH MONTH <b>FEBRUARY</b>			DAY <b>27, 1985</b>	YEAR	2b. HOUR <b>1005 AM</b>					
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH MONTH <b>11</b>			DAY <b>14</b>	YEAR <b>05</b>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS <b>79</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b>					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>A.A.</b>			13c. CITY OR TOWN <b>GLEN BURNIE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5 IDLEWOOD STREET 21061</b>					
14. FATHER'S NAME FIRST <b>IVAN</b>			MIDDLE <b></b>	LAST <b>BROWN</b>	15. MOTHER'S MAIDEN NAME FIRST <b>ALTA</b>			MIDDLE <b></b>	LAST <b>ROYER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-74-3357</b>			17. INFORMANT <b>ROGER DAVIS</b>			ADDRESS <b>GLEN BURNIE, MD. 21061</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>respiratory arrest</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <i>meophthelomia</i></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p> <p>{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>unknown</i></p>																
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p><i>chronic depression</i></p>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
<p>22a. I certify that this hospital attended the deceased from <i>Feb 19, 1985</i>, to <i>Feb 27, 1985</i>, and that in my (our) opinion death occurred on the date and hour and from the causes stated below. I (we) last saw the deceased alive on <i>2/22, 1985</i>, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) review the body after death.</p>																
22b. SIGNATURE <i>JAMES J. BENJAMIN, M.D.</i>			22c. DEGREE <i>M.D.</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>2/27/85</i>							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES J. BENJAMIN, M.D.</b>			22g. ADDRESS <b>7310 RITCHIE HIGHWAY #517 GLEN BURNIE, MARYLAND 21061</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>02-28-85</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>SECURITY PROCESS</b>			23d. LOCATION CITY OR TOWN <b>CATONSVILLE</b>			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>			ADDRESS <b>4107 WILKENS AVE.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 1 1985</b>			25b. REGISTRAR'S SIGNATURE <i>R. Davidson Rendell</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03368	EST			
1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>CHARLES</b>	MIDDLE <b>WILLIAM</b>	LAST <b>DAVIS</b>	2a. DATE OF DEATH <b>FEBRUARY 8, 1985</b>			MONTH YEAR	DAY	2b. HOUR <b>111 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>April</b> DAY <b>13</b> YEAR <b>1906</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b>			MD.				
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>						
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1205 Cedar Cliff Dr. 21061</b>						
14. FATHER'S NAME FIRST <b>Unknown</b>		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME <b>Unknown</b>		MIDDLE		LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-05-5206</b>			17. INFORMANT <b>Joyce Saffran</b> same as 13			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal bronchopneumonia</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypercapnia w COPD</i>														
DUE TO, OR AS A CONSEQUENCE OF. (c) <i>Congestive heart failure</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Chronic OAT, emphysema, liver cirrhosis</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/8</b> , 19 <b>85</b> , to <b>3/8</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Anastacio E. Subong</i>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>2/5/85</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANASTACIO E. SUBONG, M.D.</b>		22e. ADDRESS <b>206 CRAIN HIGHWAY SOUTHWEST GLEN BURNIE, MARYLAND 21061</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11 Feb. 85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Glen Haven Mem. Pk.</b>			23d. LOCATION CITY OR TOWN <b>Glen Burnie</b>		COUNTY <b>A.A.</b>	STATE <b>MD.</b>				
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley</b>		ADDRESS <b>Glen Burnie MD.</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1985</b>			25b. REGISTRAR'S SIGNATURE <i>Sheila Davidson Pendleton</i>						



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
REGISTRAR

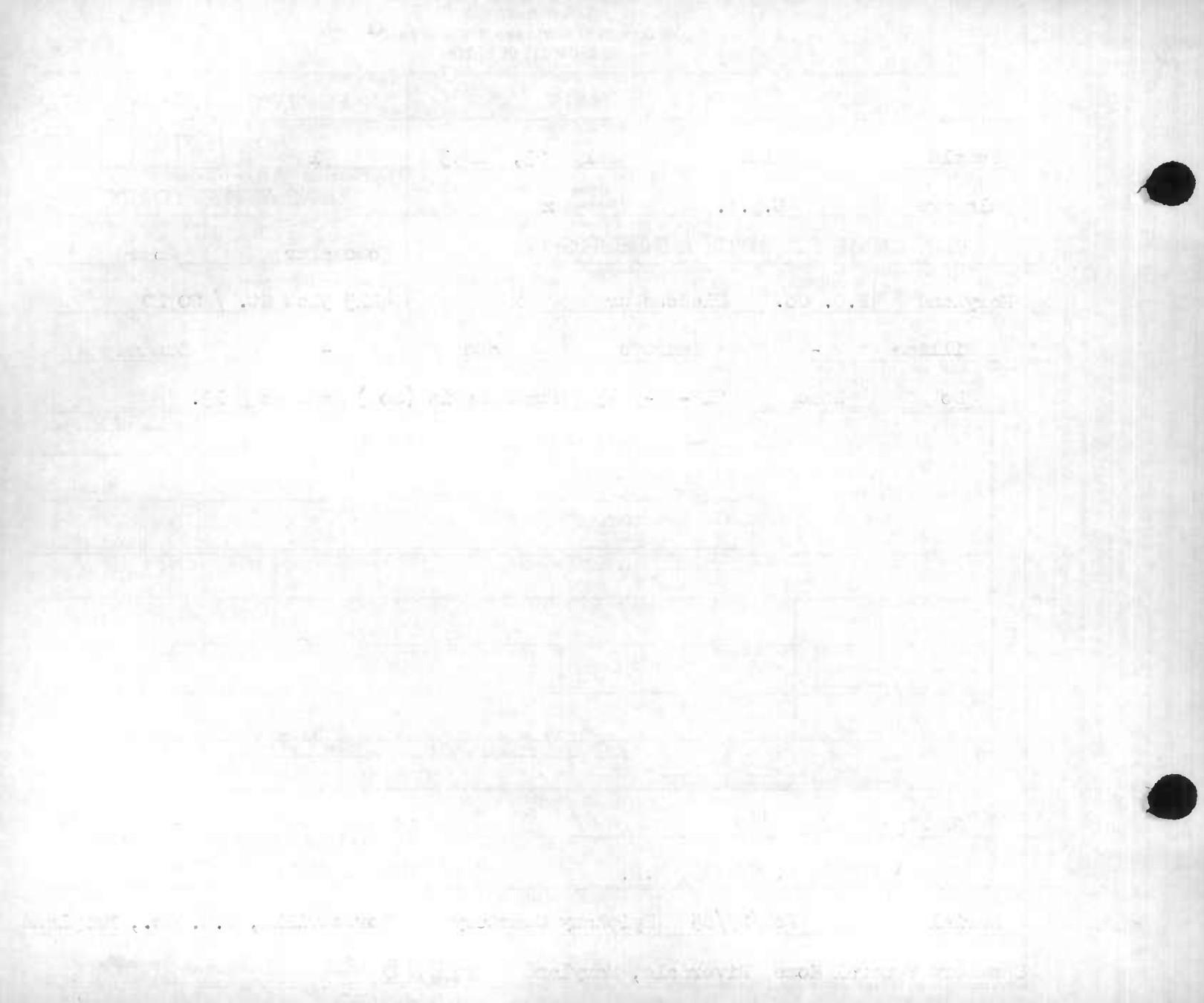
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>MARY</b>	MIDDLE <b>A</b>	LAST <b>DAVIS</b>	2a. DATE OF DEATH <b>FEBRUARY 22, 1985</b>	MONTH FEBRUARY	DAY 22	YEAR 1985	2b. HOUR 217 AM				
3. SEX <b>Female</b>			4. RACE <b>White</b>		S. DATE OF BIRTH MONTH <b>July</b>	DAY <b>23</b>	YEAR <b>1893</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE COUNTRY <b>Delaware</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b>		MD.					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>							
13a. STATE <b>Maryland</b>			13b. COUNTY <b>P.G. Co.</b>	13c. CITY OR TOWN <b>Bladensburg</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4113 51st St. / 20710</b>							
14. FATHER'S NAME FIRST <b>William</b>			MIDDLE -	LAST <b>Andrews</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Kate</b>		MIDDLE -	LAST <b>Dunham</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-64-5843</b>		17. INFORMANT <b>Frank Davis (Son) Same as # 13.</b>		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			18b. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Myocardial Infarction</b>											
			18c. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>2-21-1985</b> , to <b>2-22-1985</b> , that (I) (we) last obtained (I) (we) did not view the body after death.														
22b. SIGNATURE <b>Chackunkal V. Cyriac, M.D.</b>			22c. DEGREE <b>M.D.</b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <b>2-22-85</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHACKUNKAL V. CYRIAC, M.D.</b>			22e. ADDRESS <b>14 WELLHAM AVENUE SUITE 101 GLEN BURNIE, MARYLAND 21061</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb/25/85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Epiphany Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Forestville, P.G. Co., Maryland</b>		23e. COUNTY <b>P.G. Co.</b>		STATE			
24. FUNERAL DIRECTOR NAME <b>Chambers Funeral Home Riverdale, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 25 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Judie Davidson-Pender</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon copy patient Pages 1 & 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 21 is marked



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, CHECK EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03370

1-  
STATE  
REGISTRAR

REG. NO.

Z-14-20764

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	9c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
M	Neg	3 7 85	99			2 28 1985	2 28 1985	03370330	M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH			
maryland		USA			NEVER MARRIED DIVORCED		AA.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SURGICAL FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Shadyside		1507 Columbia Beach Rd			The Driver		20764			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
Md.		AA.		Shadyside		YES <input type="checkbox"/>		1507 Columbia Beach Rd.		
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		ADDRESS		
Joshua				Dennis		MARY JANE Griffin		Shadyside rd		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		220-16-4670		ELIZA DENNIS 1507 Columbia Beach Rd.		Cardiac Arrest.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN				
						COUNTY				
						STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>William P. Jones, MD</i>		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 2/28/85				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		695 America Ct., Davidsonville, Md. 21035						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		
Burial		3-4-1985		Dennis Griffin		Shadyside		A.D. Md		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
C. S. Hicks III		1922 Forest Ave		Mar 7 1985		The Daviden-Mendell				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is incomplete item 18 shall not be signed. Injury prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 03371				
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			Hugh			Downs; JR			FEBRUARY 16 1985			2:30 P.M.				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
MALE			CAUCASIAN			6 22 05			79 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
PENNSYLVANIA			UNITED STATES						ANNE ARUNDEL			BETHLEHEM STEEL				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
ANNAPOLIS			ANNE ARUNDEL GEN. HOSPITAL			MECHANICAL ENGINEER										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
MARYLAND			ANNE ARUNDEL			ANNAPOLIS						1142 RIVER BAY RD. 21401				
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
HUGH			Downs, Sr			MARTHA			213-07-9533			JEAN DOWNS			(SAME AS 13)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO			—			IMMEDIATE CAUSE (a)			Respiratory Failure			Jean Downs			2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b)			Respiratory Failure			DUE TO, OR AS A CONSEQUENCE OF (c)			Respiratory Failure			Many years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>4/29/71</u> to <u>2/16/85</u> , that (I) <input type="checkbox"/> did not save the deceased alive on <u>3/16/85</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (did not) view the body after death.																
22b. SIGNATURE <u>R. J. Hochman, MD</u>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>2/18/85</u>										
22d. PHYSICIAN'S NAME (TYPE OF PRINT) <u>R. J. Hochman, MD</u>			22e. ADDRESS 16 Murray Ave, Annapolis, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE FEB 18, 1985			23c. NAME OF CEMETERY OR CREMATORIAL WESTVIEW CREMATORIAL			23d. LOCATION CITY OR TOWN WESTVIEW			23e. COUNTY BALTIMORE			MD	
24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR FEB 21, 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall										

(A)

Любимый мальчик

Сколько же тебе лет, сколько же тебе лет?

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

12  
E5

CERTIFICATE OF DEATH					REG NO.
PRESTON A DOWNS			DATE OF DEATH FEBRUARY 25, 1985		254 PM
SEX Male	RACE White	DATE OF BIRTH September 15	AGE 1907 77 yrs		
STATE Maryland	COUNTRY USA	MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Baltimore City or County of Death Anne Arundel County		
TOWN OF DEATH GLEN BURNIE	NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION North Arundel Hospital		UNUSUAL OCCUPATION Carpenter		KIND OF BUSINESS OR US Government
RESIDENCE Md.	COUNTY AACo.	INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	STREET ADDRESS / ZIP CODE 969 Central La. 21054		
FATHER'S NAME Albert	MIDDLE NAME Allen	MAIDEN NAME Downs	LILLIE	Mac	Shepherd
WHO DIED #8	SOCIAL SECURITY NO. 216-18-5353		ADDRESS Madelyn Downs Same as #13		
CAUSE OF DEATH (Enter only one cause per line for Part I) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE: <u>Cardiac arrest</u>					
DUE TO OR AS A CONSEQUENCE OF <u>ASHD, hypertension A-V block</u>			TERMEDIATE CAUSE: <u>30 min</u>		
DUE TO OR AS A CONSEQUENCE OF <u>Coronary artery disease</u>			TERMINAL CAUSE OR CONDITION GIVEN IN PART II <u>Years</u>		
PART II: OTHER DEATH CONDITIONS (CHECK ONE OR MORE THAT ARE NOT RELATED TO THE TERMINAL CONDITION OR CONDITION GIVEN IN PART I) Death certificate, review by <u>40 Cardiac Infectious</u>					
DATE OF DEATH 2/17/85	CONDITION FOR WHICH OPERATION WAS PERFORMED None all (a) except		NO AUTOPSY <input type="checkbox"/> <input checked="" type="checkbox"/>	IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19	TIME OF DEATH HOUR A.M. MONTH DAY YEAR P.M. NA 19		TIME OF DEATH HOUR A.M. MONTH DAY YEAR P.M. NA 19		
PLACE OF INJURY LINE NUMBER, STREET, CITY, STATE, ZIP CODE 2010	LOCATION ROUTE 3 CENTER P.O. BOX 359		CITY MILLESVILLE, MARYLAND 21108		
DEATH OCCURRED ON THE DATE AND HOUR AND FROM THE CAUSE STATED George J. Mehl, M.D.					
ATTENDING PHYSICIAN GEORGE J. MEHL, M.D.					
DEATH ADDRESS MILLESVILLE, MARYLAND 21108					
BURIAL Burial	DATE OF CEMETERY 2-28-85		CEMETERY Baldwin U. Meth. Cem.		DATE SERVED 2/27/85
REGISTRATION NUMBER Burke Funeral Home Annapolis Md. FEB 27 1985 Peter Jordan, Jr.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please see page 3.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Please return to him/her. Then please file in the burial-travel permit. Then please remove carbon papers. Please return to him/her. Then please file in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "NO" in Part 1B, then any injury, or other traumatic event, that caused the death must be signed and dated.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. B 5 0 3 3 7 3					
1. DECEASED NAME			2. FIRST		MIDDLE		LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
<i>MARY Elizabeth</i>							<i>BROWN Duvall</i>			<i>2/18/85</i>					AM		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
<i>Female</i>			<i>Black</i>		<i>Aug 16 1901</i>			<i>83</i>			<i>MONTHS</i>		<i>DAYS</i>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
<i>Maryland</i>			<i>U.S.A</i>					<i>Anne Arundel</i>									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
<i>Glen Burnie</i>			<i>North Arundel Hospital</i>										<i>Homesteader</i>				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		12b. KIND OF BUSINESS OR INDUSTRY				
<i>MD</i>			<i>Anne Arundel</i>		<i>ANNAPOLIS</i>						<i>62 Gentry Court 21403</i>		<i>ANNE ARUNDEL</i>				
14. FATHER'S NAME			MIDDLE		LAST			15. MOTHER'S MAIDEN NAME			16. ADDRESS						
<i>JAMES</i>			<i>Wesley</i>		<i>BROWN</i>			<i>Mary ANN</i>			<i>short at Maryland Manor Nursing Home</i>						
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.										17. INFORMANT				
<i>NO</i>			<i>216-18 5338</i>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>																	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) _____																	
DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (We) attended the deceased from <i>October 12</i> , 19 <i>87</i> , to <i>February 17</i> , 19 <i>85</i> , that (we) last saw the deceased alive on <i>February 19</i> , 19 <i>85</i> , and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Peter H. Rheinstein, MD</i>			22c. DEGREE										22d. DATE SIGNED <i>Feb 19, 1985</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PETER H. RHEINSTEIN, MD</i>			22e. ADDRESS <i>MARYLAND MANOR NURSING HOME</i>														
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>			23b. DATE <i>Feb 23-1985</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>PINELAWN</i>			23d. LOCATION CITY OR TOWN <i>ANNAPOLIS</i>			23e. COUNTY STATE <i>A.D. Md</i>					
24. FUNERAL DIRECTOR NAME <i>C.E. Hicks III</i>			25a. DATE REC'D. BY REGISTRAR ADDRESS <i>1922 Forest Drive ANNAPOULS</i>										25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>				

RECEIVED



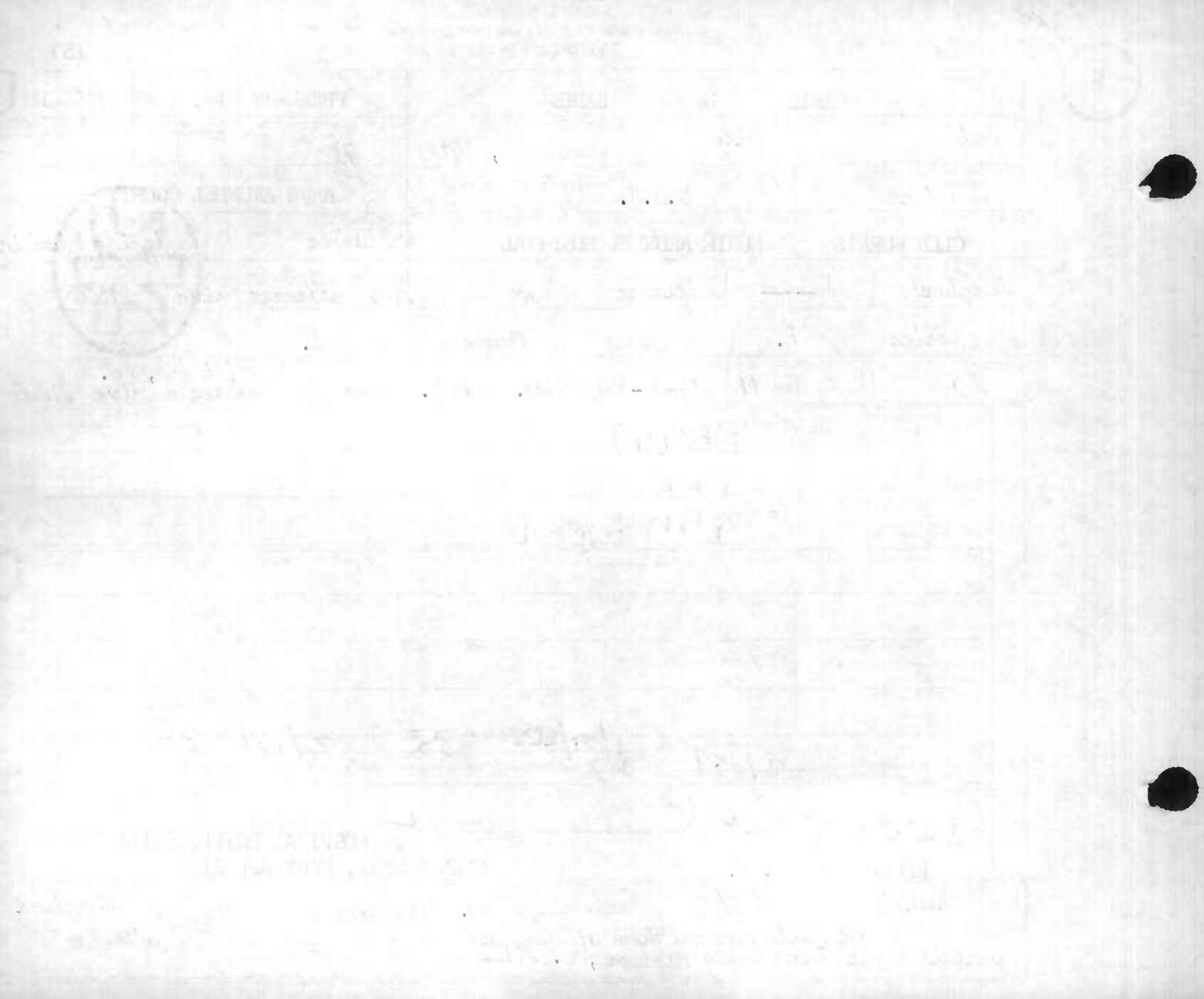
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification must be completed.

## MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						85 03374 EST			
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
MORRIS H EADES						FEBRUARY		18,	1985	735	PM	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>October 4, 1911</i>		6. AGE (IN YEARS LAST BIRTHDAY)						
						73						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i>		IF UNDER 1 YEAR MONTHS DAYS				
10. CITY OR TOWN OF DEATH <i>GLEN BURNIE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>NORTH ARUNDEL HOSPITAL</i>		12a. USUAL OCCUPATION <i>Plumber</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Ingleaside Plumbing and Heating</i>		MD.				
13a. STATE <i>Maryland</i>		13b. COUNTY <i>A.A., Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>7905 Seabreeze Drive 21226</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
14. FATHER'S NAME <i>Charles</i>		FIRST <i>Charles</i>	MIDDLE <i>F.</i>	LAST <i>Eades</i>	15. MOTHER'S MAIDEN NAME <i>Maude</i>		16. SOCIAL SECURITY NO. <i>44-26-8845</i>		17. INFORMANT <i>Mrs. Mary C. Eades</i>		ADDRESS <i>Baltimore, Md. 7905 Seabreeze Drive 21226</i>	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) <i>YES</i>		18b. IMMEDIATE CAUSE (a) <i>882vd</i>		18c. DUE TO, OR AS A CONSEQUENCE OF (b) <i>COPD</i>		18d. DUE TO, OR AS A CONSEQUENCE OF (c) <i>DM, congest.</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>1/21/85</i> , 1985, to <i>2/1/85</i> , 1985, that (I) (we) last saw the deceased alive on <i>2/1/85</i> , 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Roger Erol</i>		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS <i>325 HOSPITAL DRIVE, SUITE 104 GLEN BURNIE, MARYLAND 21061</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/22/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Meadowridge Mem. Park</i>		23d. LOCATION CITY OR TOWN <i>Dorsey</i>		23e. COUNTY <i>Howard</i>				
24. FUNERAL DIRECTOR NAME <i>Mc Gatty Funeral Home of Pasadena Mountain &amp; Tick Neck Roads Pasadena, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 25 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Johnston Pendell</i>								



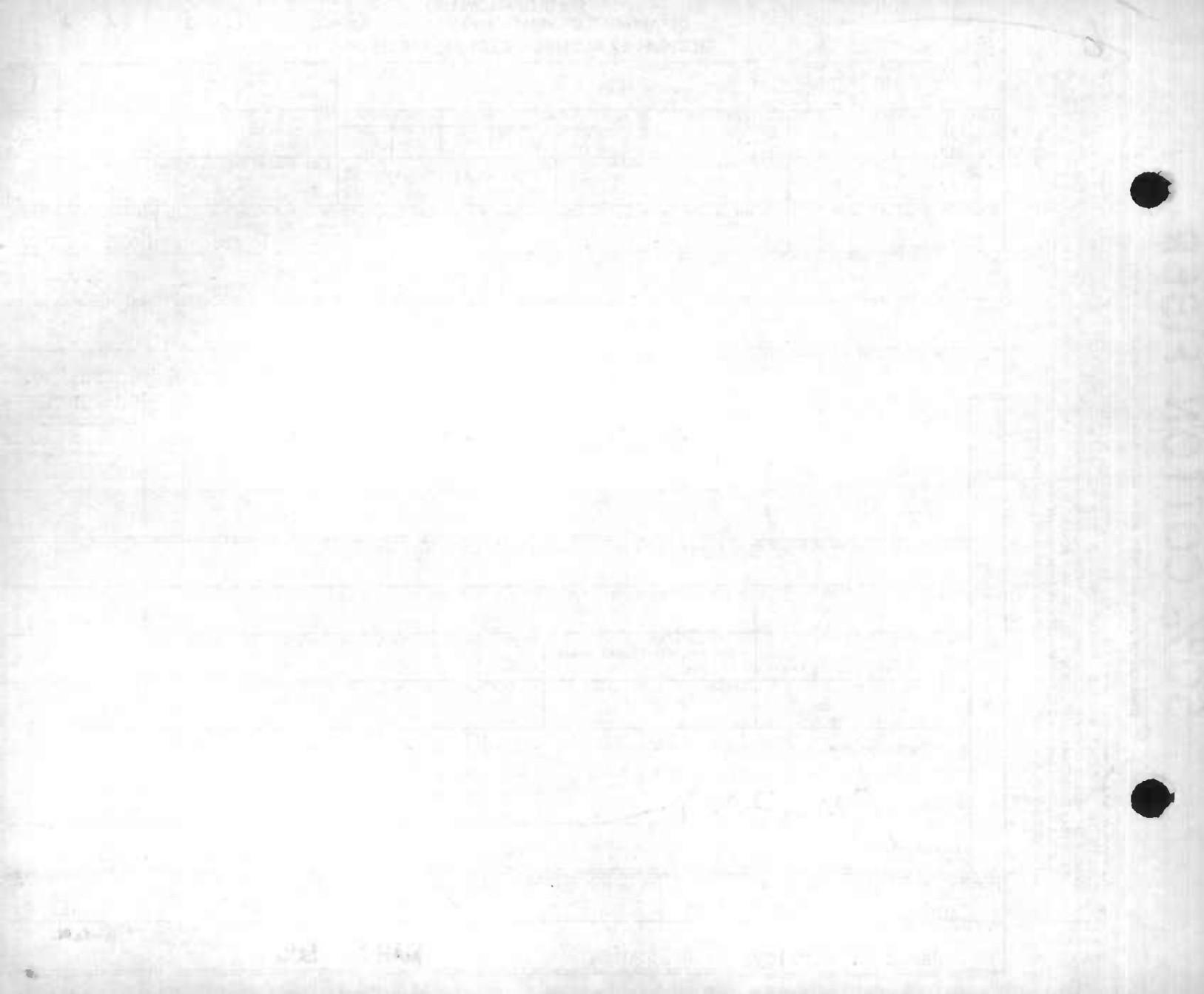
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03375

REG. NO.

1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
			MITCHELL	OWEN	EALY	<input checked="" type="checkbox"/>	2	25	1985		
3. SEX	RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	White	March 5, 1953	31			<input checked="" type="checkbox"/>	2	28	1985	3:30 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington, D.C.		USA			<input type="checkbox"/>	<input checked="" type="checkbox"/>	Anne Arundel County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Pasadena		2901 Dungate Rd.			Self-Employed			Home Improve.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS				
Maryland		AA		Pasadena			2901 Dungate Road		21122		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
		Ralph	O.	Ealy	FIRST	Lois	MIDDLE	LAST	Hubble		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			217-62-9103			Sharon Paschall, 8138 Harold Court, Apt. 2D			Glen Burnie		
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF											
(b) _____ DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
						<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an						Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion		
death resulted from:			Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE						TITLE (SPECIFY)					
						M.D. Assistant			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)			Ann M. Dixon, M.D.			ADDRESS			111 Penn St., Balto., Md. 21201		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		
Burial			March 4, 85			Glen Haven Memorial Park			Glen Burnie AA MD		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
James S. Kirkley, Glen Burnie, MD						MAR 5 1985			Glen Burnie, Md.		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3) should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85 013376			
1 - STATE REGISTRAR												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Hylda N. Eitel								2-22-85				67 yrs	7:26 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
FEMALE		WHITE		MONTH DAY YEAR		MONTHS DAYS		MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
FLA		USA		7 28 17		A.A. Co.		ANNAPOLIS		A.A. GEN. HOSP.		INSURANCE AUTO CLUB			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		13f. ADDRESS		MD A.A. SEVERNA PK X 272 FERTSCH RD.			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
WALTER B. NEAL				FLORENCE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		260180458		KAY MOFFETT - ABOVE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1979</u> , 19, to <u>2/22/85</u> , 19, that (I) (we) lost saw the deceased alive on <u>2/21/85</u> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.		22b. SIGNATURE <u>Stanley Watcins</u>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED <u>2/22/85</u>											
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE					
CREMATED 2/22/85		Westview Crem		Westview		BALTIMORE		BALTIMORE		MD					
24. FUNERAL DIRECTOR NAME		ADDRESS		25d. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Robert Banacos Severna Ph. Md				FEB 23 1985		<u>Stanley Watcins</u>									
DHMH - 16 60M 7/84 (VRA 15, 4)															



1936  
MAY 10  
1936  
1936

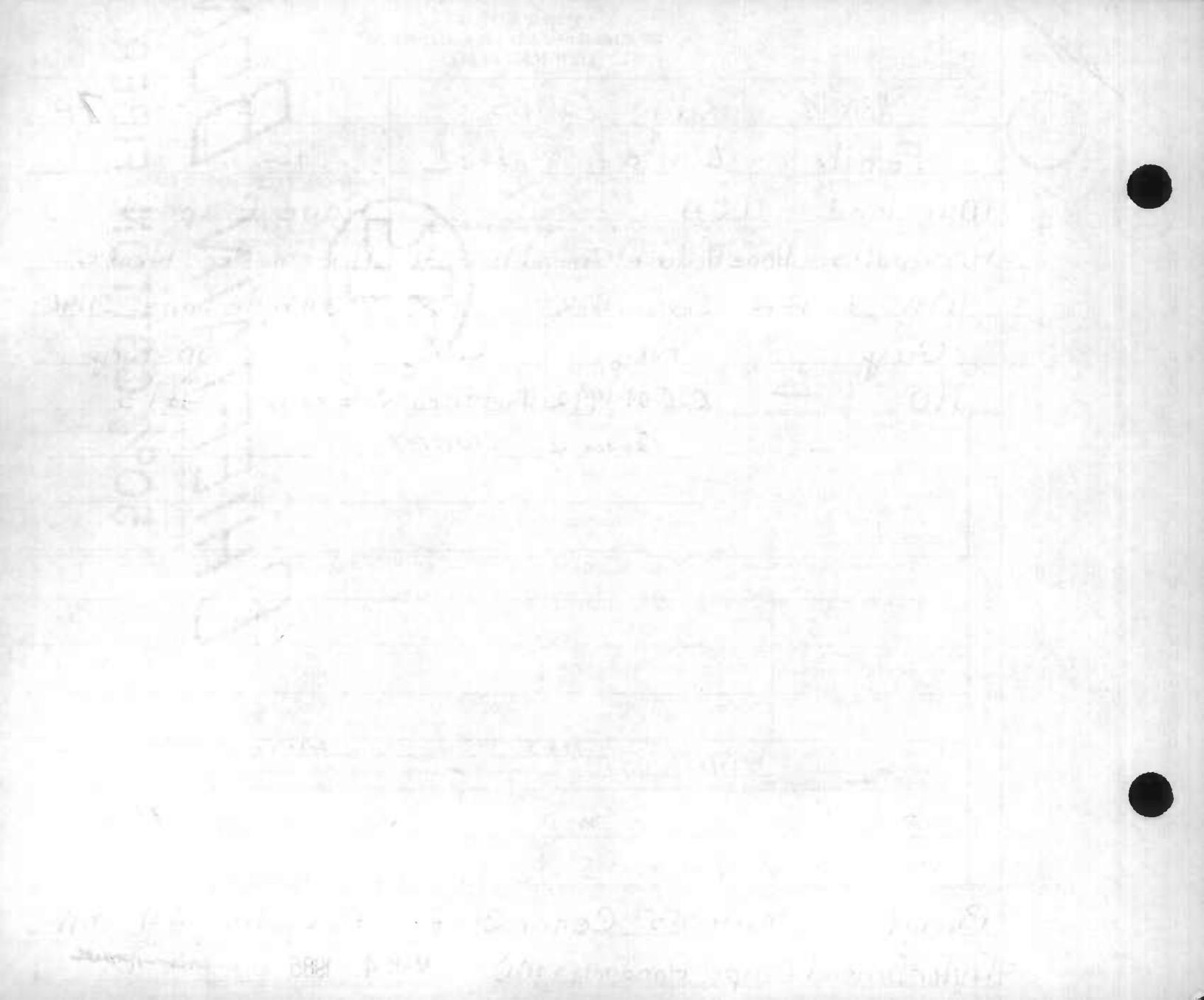
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 03371										
										REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR								
Nancie			Ray	Evans		2-28-85						7p M								
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR									
Female			White		8-27-12			72			MONTHS	DAYS	HOURS	MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Anne Arundel											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Annapolis			Anne Arundel General Hospital						Homemaker			Home								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE										
MD			Anne Arundel		Severna Park		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			303 Maple Lane 21146										
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME														
Guy					Ray	Lucy														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			220-01-1992			Matthew S. Evans-									Cancer of Ovary					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			220-01-1992			Matthew S. Evans-														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1983, 19, to 2/28/85, 19, that (I) (we) last saw the deceased alive on 2/28/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																				
22b. SIGNATURE			22c. DEGREE			ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED											
Stanley P. Watkins Jr MD															3/1/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			51 Franklin St, Annapolis, MD														
Burial			Mar 4, 1985			Cedar Bluff			Annapolis			AA			MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY			STATE					
Burial			Mar 4, 1985			Cedar Bluff			Annapolis			AA			MD					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Taylor Funeral Chapel-Annapolis, MD						MAR 4 1985			Laudson-Randall											



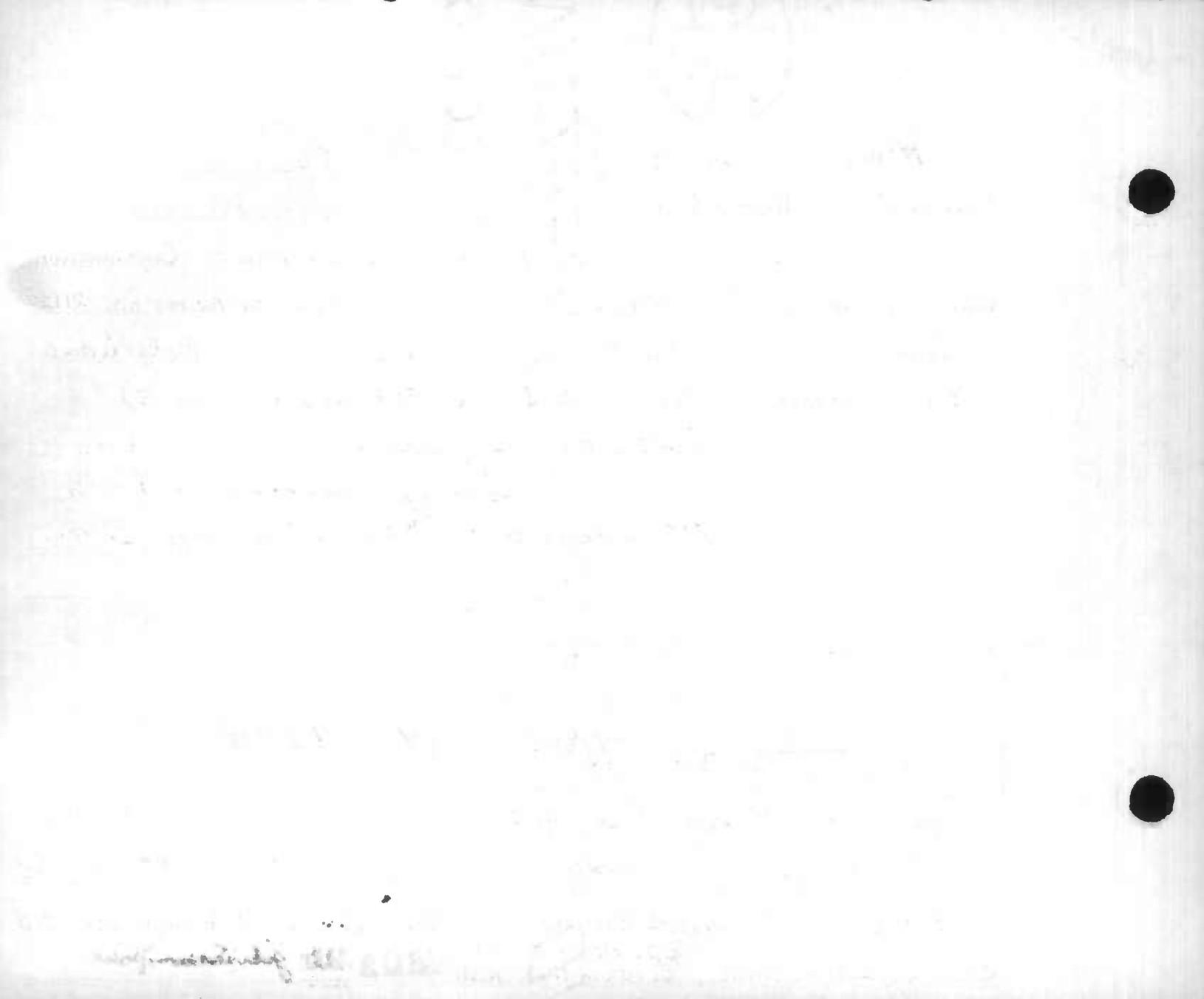
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and stamped by [REDACTED] in the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 thru 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 35 03378	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Joseph R</i>	MIDDLE <i> </i>	LAST <i>Farrell</i>	2a. DATE OF DEATH MONTH DAY YEAR <i>2 23 85</i>	2b. HOUR <i>2:10 A-M</i>
3. SEX <i>MALE</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>3 31 28</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>56</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i> </i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>NEW YORK</i>		7b. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>ANNE ARUNDEL MD.</i>	
10. CITY OR TOWN OF DEATH <i>ANNAPOLIS</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ANNE ARUNDEL GEN.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SUPERINTENDENT</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>CONSTRUCTION</i>	
13e. STATE <i>MARYLAND</i>		13b. COUNTY <i>ANNE ARUNDEL</i>	13c. CITY OR TOWN <i>PASADENA</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>257 MAGOTHY BRIDGE RD. 21122</i>	
14. FATHER'S NAME FIRST <i>JOHN</i>		MIDDLE <i> </i>	LAST <i>FARRELL</i>	15. MOTHER'S MAIDEN NAME FIRST <i>CATHERINE</i>		MIDDLE <i> </i>	LAST <i>McCLELLAND</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>KOREA 077-20-4093</i>		17. INFORMANT <i>DORTHEA J. FARRELL (SAME AS 13)</i>		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of lung</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>dissemination of pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>massive intra thoracic hemorrhage</i> 30 min. 1/2 inch							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i> </i>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) <i> </i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i> </i>		21f. LOCATION STREET <i>84</i>	CITY OR TOWN <i>22 Feb 85</i>	COUNTY <i> </i>	STATE <i> </i>
22a. I certify that (I) <i>was</i> hospitalized attended the deceased from <i>1 Nov</i> , 19 <i>84</i> , to <i>22 Feb 85</i> , that (II) <i>was</i> last saw the deceased alive on <i>22 Feb 1985</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>did</i> (II) <i>did not</i> view the body after death.							
22b. SIGNATURE <i>John M. Richardson, M.D.</i>		DEGREE <i> </i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>2/23/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John M. Richardson</i>		22e. ADDRESS <i>104 Foster Street Annapolis</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>FEB. 26, 1985</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>MARYLAND VETERAN CEM.</i>		23d. LOCATION CITY OR TOWN <i>CROWNVILLE ANNE ARUNDEL MD</i>		
24. FUNERAL DIRECTOR NAME <i>BARRANCO FUNERAL HOME</i>		25a. ADDRESS <i>501 RITCHIE HWY. SEVERNA PARK, MD.</i>		25b. DATE REC'D. BY REGISTRAR <i>MAR 6 1985</i>			
				25c. REGISTRAR'S SIGNATURE <i>J. Richardson Pendell</i>			



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.					
1 - STATE REGISTRAR			1. DECEASED NAME FIRST MIDDLE LAST									2a. DATE KNOWN OF ESTI. DEATH MATED					
			ANTHONY MICHAEL FEDI									<input checked="" type="checkbox"/> 2 24 1985 2038 AM					
3. SEX Male			4. RACE Cauc.			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS) LAST BIRTHDAY			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. HOUR			
						11 9 1957			27 YRS.					2d. HOUR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.								
10. CITY OR TOWN OF DEATH Anne Arundel Co. North Arundel Gen. Hospital			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14. STREET ADDRESS 3508 Gough St. 21224					
14. FATHER'S NAME FIRST Pasquale			MIDDLE			LAST Fedi			15. MOTHER'S MAIDEN NAME FIRST Judith			MIDDLE			LAST Stringfield		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-76-8270									17. INFORMANT Mrs. Karen Fedi, 3508 Gough St.			ADDRESS 21224		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneum + abdominal trauma -</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>motorcycle accident</i> DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20 AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER		
ACTUAL SIGNATURE <i>James E. Wheeler</i>			DATE SIGNED <i>2/24/85</i>														
EXAMINER'S NAME (TYPE OR PRINT) James E. Wheeler, M.D.			ADDRESS 910 Primrose Rd. Annapolis, 21403														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 2-26-85			23c. NAME OF CEMETERY OR CREMATORIAL Security Process			23d. LOCATION CITY OR TOWN Baltimore, Maryland			COUNTY STATE					
24. FUNERAL DIRECTOR Joseph N. Zannino, 263 S Conkling St. 21224									25a. DATE REC'D. BY REGISTRAR FEB 26 1985			25b. REGISTRAR'S SIGNATURE <i>Lia Davidson-Randall</i>					
BP			DHMH - 17 (VR A15 ME (5)) 20M 4/B2														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 22 shows any injury, an other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 85 03380				
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Morris	G.		Feldman	2-20-85				5:40AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)						
Male	White	MONTH 5 - DAY 6 - YEAR 1908	76	IF UNDER 1 YEAR	IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA			ANNE Arundel					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY
Annapolis	ANNE Arundel				Retail Sales				Liquor
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE					
Maryland	Anne Co	Annapolis	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	22 Murray Ave. 21401					
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST		
Harry			Feldman	Sava			Sartowsky		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No	215-03-2249	Julia L. Feldman	Same as #13	Minutes					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

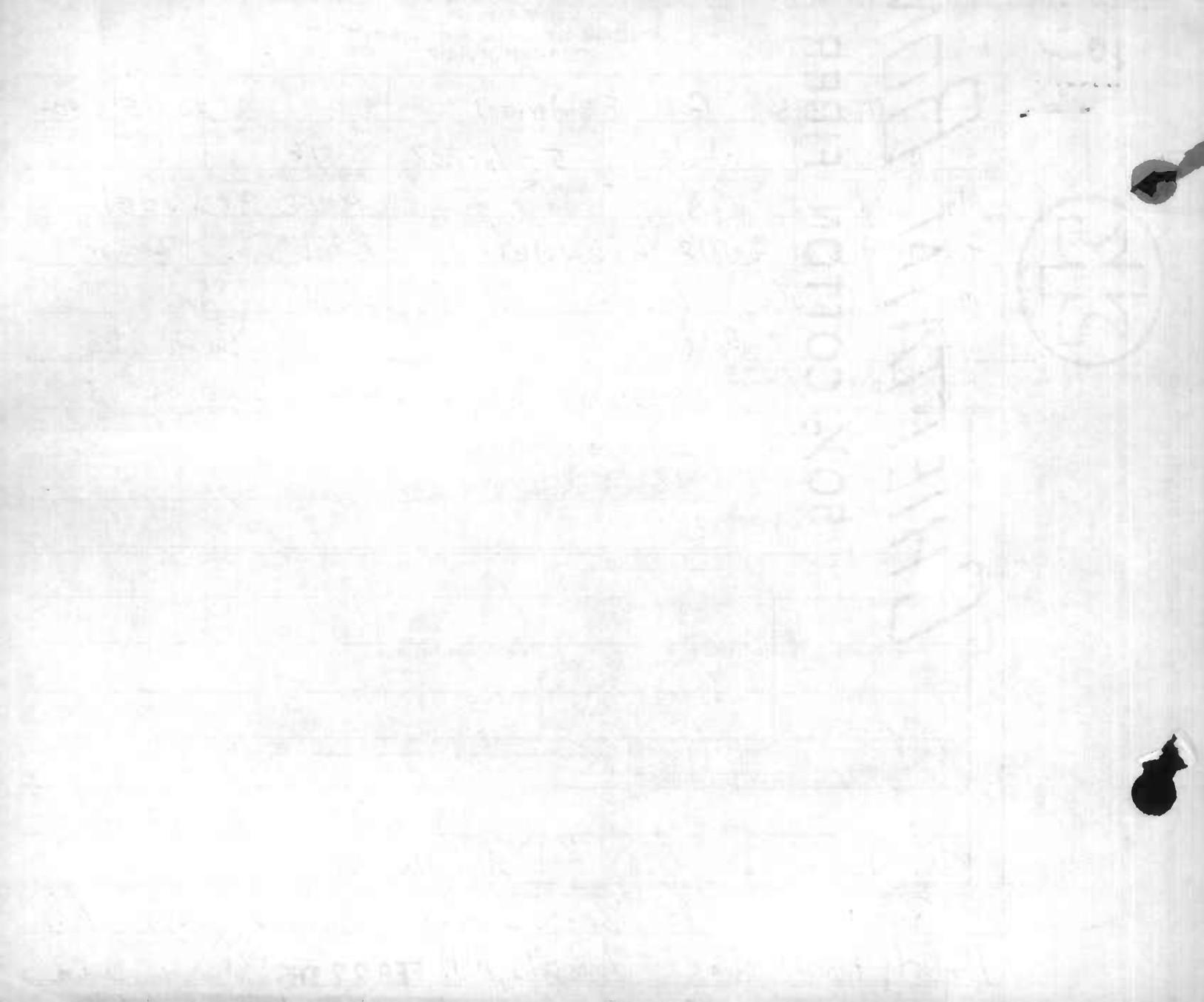
(b) Arteriosclerotic C-V disease.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE  Dr. Peeler	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2/20/85-
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Peeler	22e. ADDRESS Annapolis, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-21-85	23c. NAME OF CEMETERY OR CREMATORIAL Kneseth Israel	23d. LOCATION CITY OR TOWN Annapolis, Md.
24. FUNERAL DIRECTOR NAME Hardy's Funeral Home	ADDRESS Annapolis, Md.	25a. DATE REC'D. BY REGISTRAR FEB 27 1985	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall



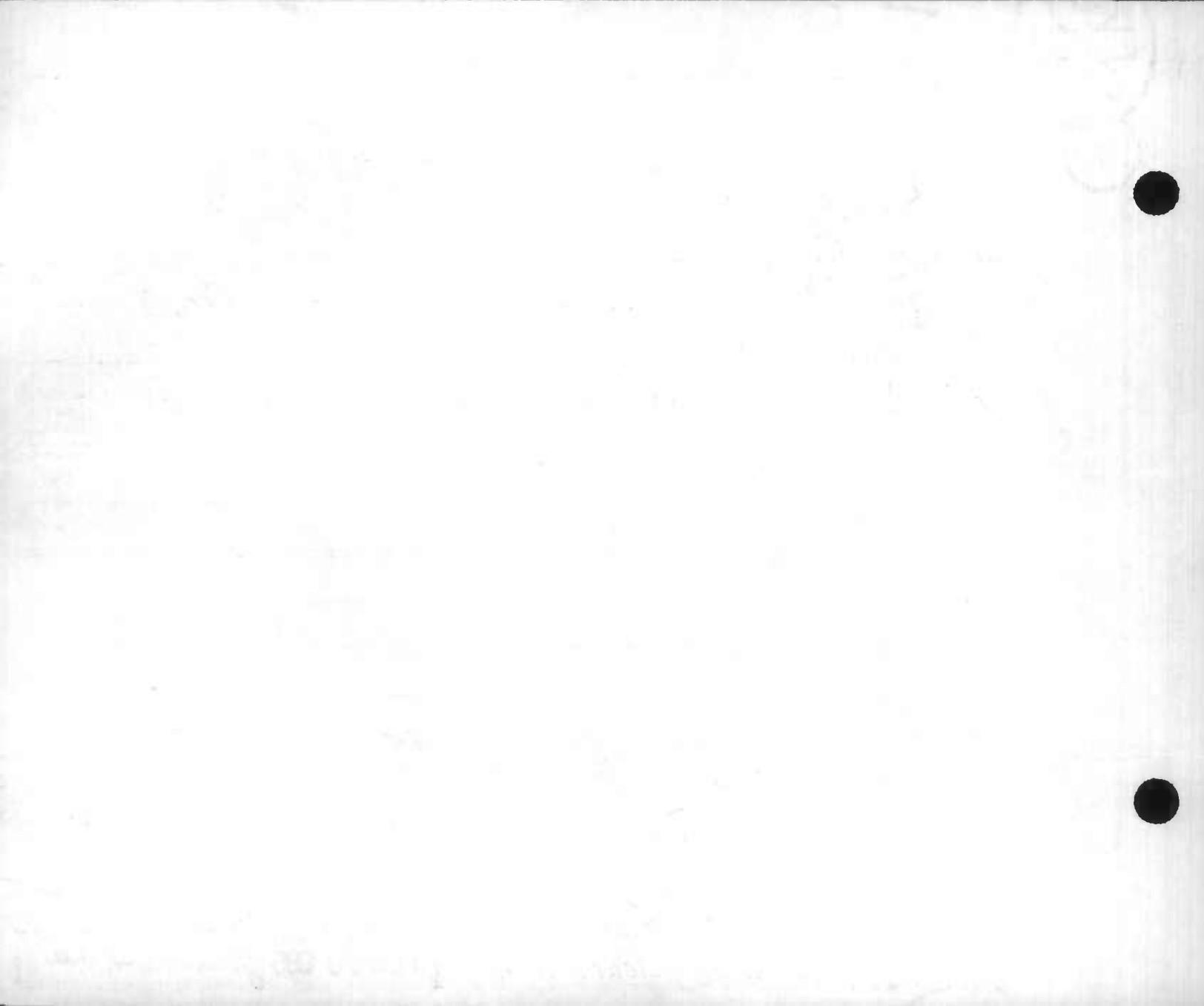
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, related by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical certification must be signed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						85 03381		
						REG. NO.		
1 - FOR STATE REGISTRAR	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
I. DECEASED NAME (TYPE OR PRINT)	Mildred	H	Ferris	February 2, 1985				40
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Female	WHITE	MONTH	DAY	YEAR	62 yrs	YRS.		6 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
DEL.	USA	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	A.A. Co.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13b. KIND OF BUSINESS OR INDUSTRY
Annapolis	A.A. GEN. Hosp				NURSE			Hosp.
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21146
MD	AA	BEVERLY PK				154 Boone Trail		
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		MIDDLE		LADY
	Paul		KENNY	Miriam		Euston		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)	16b. SOCIAL SECURITY NO.		16c. INFORMANT		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
NO	222102659		Dear C Ferris - Ebone					7 years
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lymphoma								
DUE TO, OR AS A CONSEQUENCE OF (b) { DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED  AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I/this hospital) attended the deceased from 11/5 19 85 to 2/2 19 85, that (I/we) last saw the deceased alive on 2/2 19 85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) did/did not view the body after death.								
22b. SIGNATURE EW Cole III								
22c. DATE SIGNED 2/2/85								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22f. ADDRESS 51 FRANKLIN ST ANNAPL Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 2-4-85	23c. NAME OF CEMETERY OR CREMATORIAL Westview Cemetery		23d. LOCATION CITY OR TOWN COLONY STATE Baltimore, Md.				
24. FUNERAL DIRECTOR NAME Abut St. Bananas, Seneca Rd.					25a. DATE REC'D. BY REGISTRAR FEB 06 1985	25b. REGISTRAR'S SIGNATURE John J. Henklein, Jr.		
DHMH - 16 50M 4/83 (VRA 15, 4)								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Roger Hand should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked **BURIAL**, then any injury, or other traumatic event, the medical examiner must be notified.

**MEDICAL CERTIFICATION**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8503382			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Emma			Barbara	FINN		Feb. 25, 1985						M	
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		
Female			White		July 28, 1894						IF UNDER 1 YEAR YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH					
New Jersey			USA		NEVER MARRIED DIVORCED			Anne Arundel			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis			Annapolis Convalescent Ctr.			Homemaker			Home				
13a. STATE			13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
MD			A. A.		Annapolis			14 Upshur Avenue 21403					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS					
Cegelski					Mrs. John E. Thommen.			Same as #13					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO						Cerebral Vascular Disease			Several years				
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Disease</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22a. I certify that (I) (this hospital) attended the deceased from April 4, 1976, to 2/25, 1985, that (I) last saw the deceased alive on 1/19, 1985, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.													
22b. SIGNATURE <i>R. J. Hochman, M.D.</i>			DEGREE <i>M.D.</i>			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/25/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			16 Murray Ave., Annapolis, MD 21401							
Richard I. Hochman, M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____				
Burial			Feb 28 1985			Holy Cross			Brooklyn A.A. MD				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Taylor Funeral Chapel - Annapolis, MD						FEB 26 1985			Julia Davidson-Pandell				



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8503383

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<u>Virginia</u>					<u>Fiscella</u>	<u>2-26-85</u>				<u>6:25 AM</u>
3. SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	
<u>F</u>	<u>W</u>	<u>10-06-10</u>				<u>74</u> YRS				
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel</u> MD.			
CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
<u>Severna Park</u>	<u>Meridian Severna Park</u>						<u>Registered Nurse</u>			
13a. STATE <u>New Jersey</u>			13b. CITY OR TOWN <u>Cape May</u>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <u>5708 PARK BLVD 08260</u>	
14. FATHER'S NAME FIRST <u>James</u>			MIDDLE <u>Atkinson</u>			15. MOTHER'S MAIDEN NAME <u>I Sabella</u>			16b. KIND OF BUSINESS OR INDUSTRY <u>Hosp. 999999 08260</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. <u>199-28-0292</u>			17. INFORMANT			18. ADDRESS <u>SEVERNA PARK MERIDIAN NURSING CENTER</u>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))      PART I. DEATH WAS CAUSED BY:      IMMEDIATE CAUSE (a) _____      DUE TO, OR AS A CONSEQUENCE OF      Conditions, if any, which      gave rise to immediate      cause (a), stating the      underlying cause last      (b) <u>cardiac arrest</u>      DUE TO, OR AS A CONSEQUENCE OF      (c) <u>congestive heart failure</u></p>										
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  <u>Diabetes mellitus, hypertension</u></p>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) that (I/we) last						
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from now the deceased gave an above (we) did not view the body after death.		215 19 85 June 19 85		22b. DATE						
22c. SIGNATURE THE PHYSICIAN'S NAME (TYPE OR PRINT)		22d. DEGREE		22e. ADDRESS			22f. DATE SIGNED			
<u>George C. Samuels</u>		<u>MD</u>		<u>205 Ridgely Ave - Annapolis, MD</u>			<u>26 Oct 85</u>			
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE <u>3-2-85</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Cape May Co. Cemetery Cape May NJ</u>			23d. LOCATION CITY OR TOWN			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRATION CUSTodian'S SIGNATURE						
<u>John Bannister Severna Park MD</u>				<u>MAR 04 1985 John Bannister</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon copies; pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "NO" show any injury, or other traumatic event, the medical examiner should be notified.

20X COLORADO BIRDS

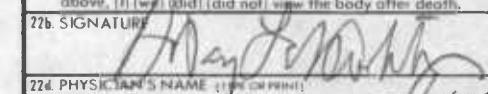


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03384	
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR	
1a. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
CATHERINE V. FOLKER							2 11 85			M	
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE			WHITE	7 3 22			62			YRS.	
7a. BIRTHPLACE COUNTRY MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY		
10. CITY OR TOWN OF DEATH MILLERSVILLE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 23 Larbo Rd. Millersville 21108			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.-Salesmanager Harley's			12b. KIND OF BUSINESS OR INDUSTRY MD.		
13a. STATE MARYLAND			13b. COUNTY ANNE ARUNDEL			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 21108 23 Larbo Rd. Millersville, Md.		
14. FATHER'S NAME Martin Riddle			15. MOTHER'S MAIDEN NAME Windich, Sr.			FIRST Matilda			MIDDLE Roe		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 212-32-3264			17. INFORMANT John E. Folker 4002 Rustico Rd. 21220			ADDRESS		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.			DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 4401			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE 			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2-19-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HILARY T. O'HERLIHY, MD (761-4848)			22e. ADDRESS 325 Hospital Dr. Suite 208 GlenBurnie 21061								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-14-85			23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith			23d. LOCATION CITY OR TOWN Baltimore Maryland		
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home			24b. ADDRESS 1401 Belair Rd. BALTO. MD. 21236			24c. DATE REC'D. BY REGISTRAR FEB 19 1985			24d. REG. DATE & SIGNATURE John Davidson - Riddle		

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR IN PENCIL IN ITEM 24. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, P.M. 3, RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 3 AND 2 SHOULD BE FILLED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 03385	
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. MARRIED WIDOWED	10. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	11. HOUR		
m	Can	7 1 32	52 yrs	MONTHS	DAYS	HOURS	2 FEB 13 1985	11 2 13 1985	12 MONTH	DAY	YEAR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		United States				Never Married Divorced		AA					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Annapolis		Anne Arundel General				Retired		Military					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE	13b. COUNTY	13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS						
Md.	A.A.	Arnold					1246 Dogwood Rd -						
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST						
FRANK			FORD	RITA			Mc						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
YES		1951-1977		213-28-7307		RITA DAKLEY (SAME AS 13)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Cardiogulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>													
{ (b) <u>ASCD</u> DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b). <u>C.V.A., Sigmoid colostomy w/ colostomy.</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY) William P. Jones, M.D.				MEDICAL EXAMINER				DATE SIGNED 2/13/85			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 695 America Cr., Davidsonville, Md. 21035											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Feb. 15, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Maryland Veterans Cem.		23d. LOCATION Crownsville		COUNTY Anne Arundel	STATE MD				
24. FUNERAL DIRECTOR NAME		ADDRESS 501 Ritchie Hwy.		25a. DATE REC'D. BY REGISTRAR FEB 20 1985		25b. REGISTRAR'S SIGNATURE William P. Jones							
BP		BARRANCO FUNERAL Home SEVERNA PARK, MD											
DHMH - 17 (VR A15 ME (5))													
20M 4/B2													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retorted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 3 3 8 6			
1 - STATE REGISTRAR												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Dario B. Gaddi						February 5, 1985						10:30 P.M.			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			Caucasian			Jan. 28, 1898			87			MONTHS		DAYS	
7b. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Anne Arundel MD.			
Italy			US												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Annapolis			Anne Arundel General Hospital			Retired			Baker						
13a. STATE Maryland			13b. COUNTY Prince Georges Greenbelt			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7815 Mandan Road 20770						
14. FATHER'S NAME FIRST Dario			MIDDLE B.			15. MOTHER'S MAIDEN NAME FIRST Marie			LAST E.			Gaddi			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT Theresa B. Rankin-dtr.			ADDRESS 993 Hillendale Drive Annapolis, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one wk			
no			217-32-9889												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>															
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____															
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) this hospital attended the deceased from saw the deceased alive on 215 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						1/31 19 85			2-5 19 85						
22b. SIGNATURE <i>Daniel Chaconas</i>						DEGREE MS			ATTENDING PHYSICIAN			MEDICAL DIRECTOR		STAFF PHYSICIAN	22c. DATE SIGNED 2-6-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CHACONAS</i>			22e. ADDRESS 1521 Ritchie Hwy Arnold Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Feb 7, 1985			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood, Maryland			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>R. Dealy</i> Beall Funeral Home			16000 Annapolis Rd. Bowie, Maryland 20715			25a. DATE REC'D. BY REGISTRAR FEB 11 1985			25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Rendell</i>						

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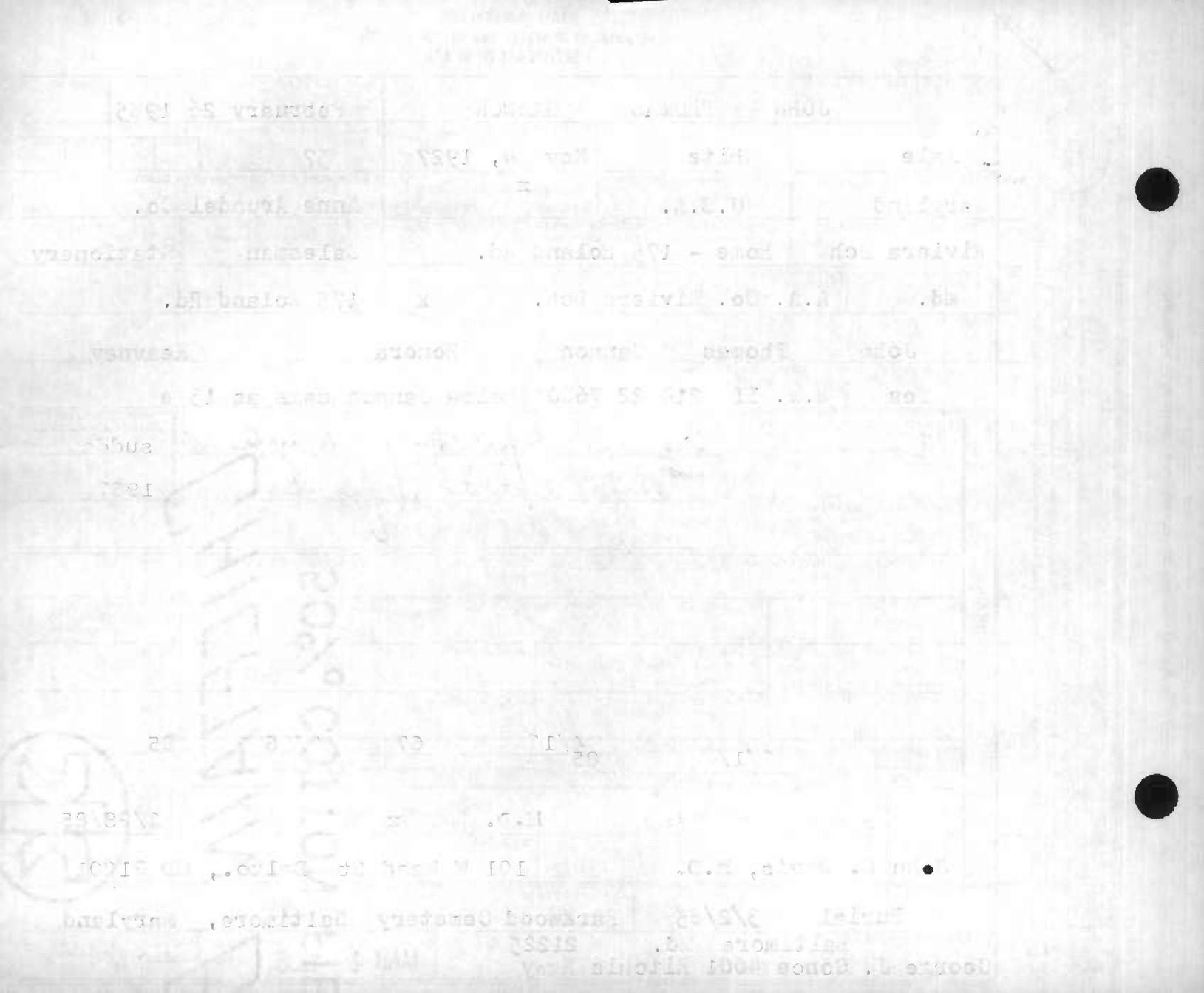
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial; cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

1 - FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 8503387					
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR		
JOHN THOMAS GANNON						February 26 1985								
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White	Nov 4, 1927			57 YRS.			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.						Anne Arundel Co. MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
Riviera Bch		Home - 175 Roland Rd.						Salesman				Stationery		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Md.		A.A. Co.		Riviera Bch		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		175 Roland Rd. 21122						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME									
		John	Thomas	Gannon	Honora									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
Yes		W.W. II			214 22 7680			Thelma Gannon same as 13 e						
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF (c) <u>1967</u> sudden														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> , 19 <u>67</u> , to <u>2/26</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/17</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>John R. Davis, M.D.</i>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/28/85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Davis, M.D.		22e. ADDRESS 101 W Read St Balto., MD 21201												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/2/85		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery			23d. LOCATION CITY OR TOWN Baltimore, Maryland		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME George J. Goncze		ADDRESS 4001 Ritchie Hwy			25a. DATE REC'D. BY REGISTRAR MAR 4 1985			25b. REGISTRAR'S SIGNATURE <i>Julie Anderson-Kendall</i>						
BP _____														

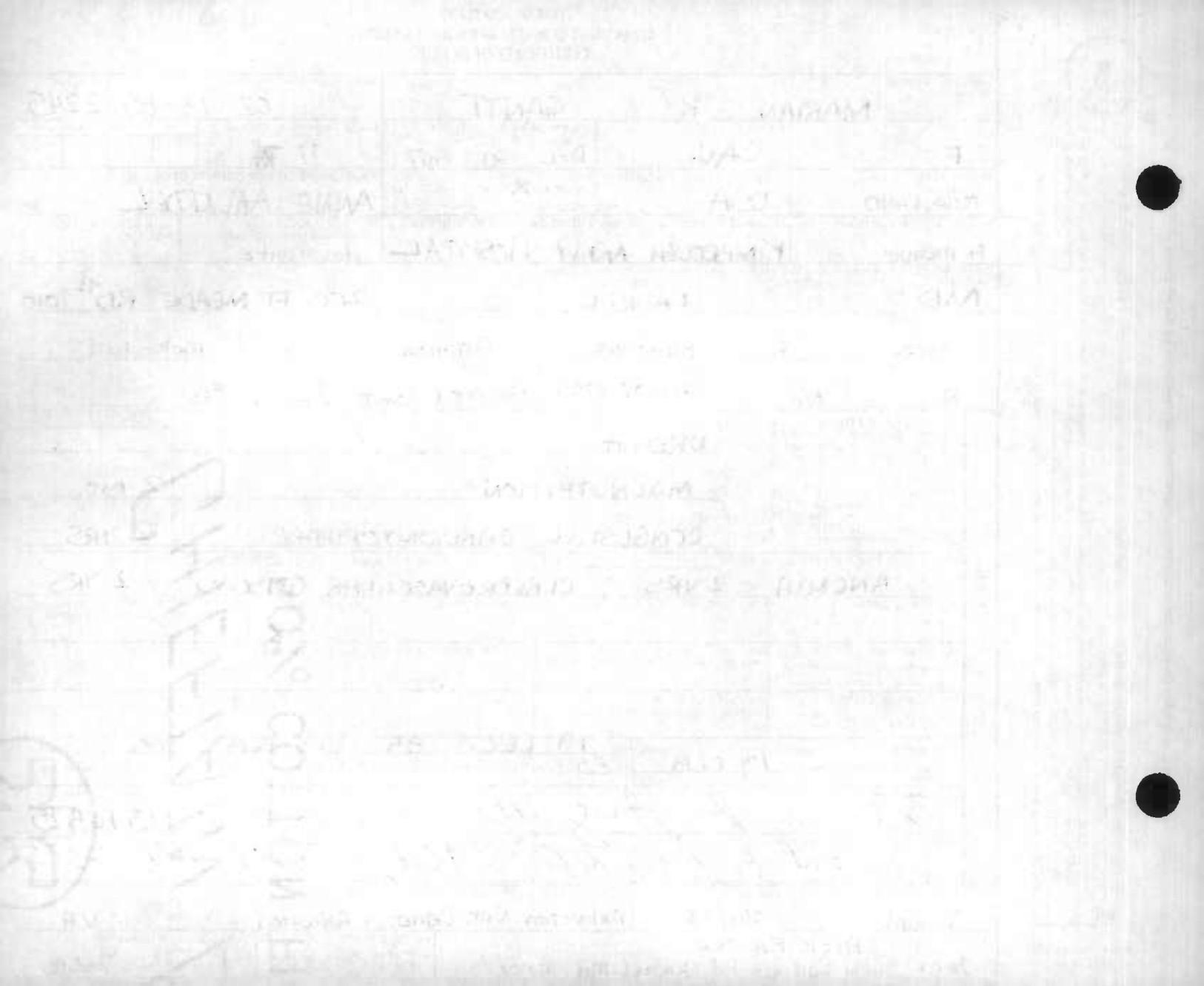


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit's permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be panted or one

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. <i>03383</i>											
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR		
<i>MARIAN K GANTT</i>									<i>02 - 13 - 85</i>		
3. SEX <i>F</i>			4. RACE <i>CAU.</i>			5. DATE OF BIRTH MONTH <i>DEC</i> DAY <i>20</i> YEAR <i>1907</i>			6. AGE (IN YEARS LAST BIRTHDAY) 77 <i>78</i> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>ANNE ARUNDEL MD.</i>		
10. CITY OR TOWN OF DEATH <i>H. MEADE</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>KIMBROUGH ARMY HOSPITAL</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>MD</i>			13b. COUNTY <i>HHR</i>			13c. CITY OR TOWN <i>LAUREL</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS <i>200 FT MEADE RD # 1010</i>			13f. STREET ADDRESS <i>20135</i>								
14. FATHER'S NAME FIRST <i>HARRY</i> MIDDLE <i>F.</i> LAST <i>KLEINTANK</i>			15. MOTHER'S MAIDEN NAME FIRST <i>GERTRUDE</i> MIDDLE <i>V.</i> LAST <i>MCCLUSKER</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>217-07-8727</i>			17. INFORMANT <i>GEORGE B. GANTT Same HS # 13E</i>					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) APPROXIMATE INTERVAL PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UREMIA</i> BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>MALNUTRITION</i> 2 MO.											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>CONGESTIVE CARDIOMYOPATHY</i> 2 YRS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <i>ANEMIA - 2 yrs ; CEREBROVASCULAR DISEASE - 2 yrs.</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>19 DEC 1985</i> to <i>13 FEB 1985</i> , that (I) (we) last saw the deceased alive on <i>13 FEB 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. MEDICAL CERTIFICATION <i>Vincent P. Ang MD</i>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>13 FEB 85</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Vincent P. Ang MD</i>			22e. ADDRESS <i>RACH, FGGM, MD 20755</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>3/18/85</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>ARLINGTON NAT. CEMET.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>ARLINGTON VA</i>		
24. FUNERAL DIRECTOR NAME <i>Fleck F.H. INC.</i> ADDRESS <i>7601 SANDY SPRING Rd. LAUREL Md. 20707</i>						25a. DATE REC'D. BY REGISTRAR <i>FEB 20 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendle</i>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												0 3 3 8 9		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			XX	MONTH	DAY	YEAR	2b. HOUR	
Howard J. Gardner						IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2-25	19 85	M
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR 4:05 p.m.			
Male		Caucasian	May 22, 1924	60 yrs.	2d. DATE PRONOUNCED DEAD			2-25	19 85	2d. HOUR 4:05 p.m.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA			EVER MARRIED DIVORCED			Anne Arundel County, MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Crofton			1709 Fallsway Drive						Self employed			Produce		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland			Anne Arundel		Crofton				1709 Fallsway Drive		21114			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST					
Martin			Edward	Gardner	Ida			Grace	Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  no			16b. SOCIAL SECURITY NO.  579-40-3160			17. INFORMANT  Earlene Gardner			same as 13e			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) Shotgun wound of Head  DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.  (b)  DUE TO, OR AS A CONSEQUENCE OF  (c)														
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 2-25 19 85			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  subject shot himself			21d. LOCATION STREET 1709 Fallsway, Crofton, Anne Arundel Co., Md.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Dennis F. Smyth, M.D.			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion								
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS						TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 2-26-85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			Mar 2, 1985			Southern Memorial Gardens			Dunkirk, Maryland					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Beall Funeral Home			16000 Annapolis Rd. Bowie, Md.			MAR 1 1985			Greta Davidson-Randall					

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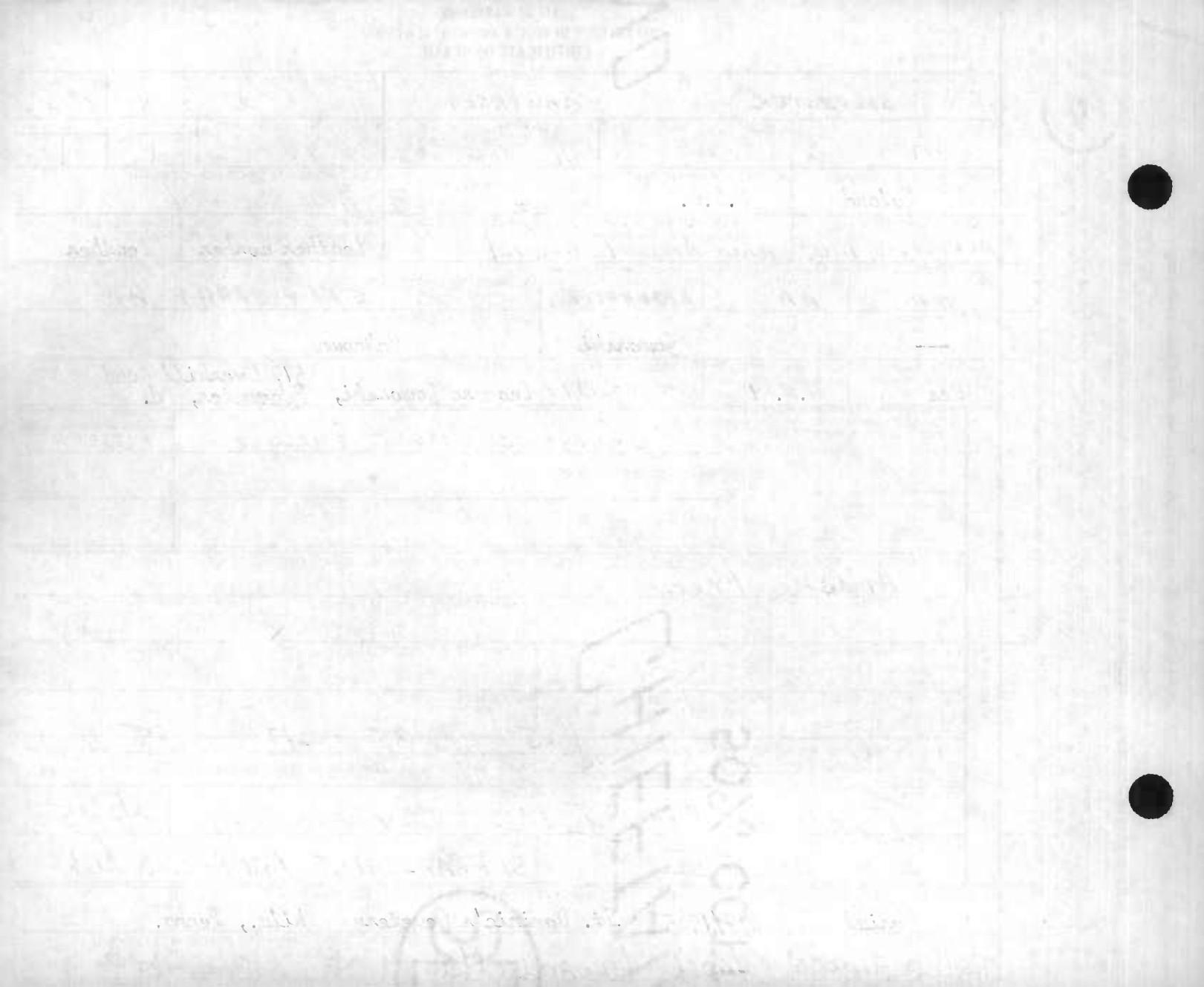
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "No" (no history of injury, or other traumatic event), the medical examiner may be notified of one.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 5 0 3 3 9 0				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 2 2 85									2b. HOUR 9 4 2 A M				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
SILVESTER						GAWORSKI			10 06 88							
3. SEX <i>m</i>			4. RACE <i>w</i>			7. DATE OF BIRTH MONTH DAY YEAR			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i>			MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Poland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			10. CITY OR TOWN OF DEATH <i>ANNAPOLIS, MD.</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Leather worker</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Leather</i>	
13a. STATE <i>MD.</i>			13b. COUNTY <i>AA</i>			13c. CITY OR TOWN <i>EGEWEATER</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>517 OVERHILL DR.</i>				
14. FATHER'S NAME FIRST ---			MIDDLE			LAST <i>Gaworski</i>			15. MOTHER'S MAIDEN NAME FIRST Unknown			MIDDLE			LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. <i>W.W. 1 165-05-1993</i>			17. INFORMANT PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>			18. RESS <i>Overhill Road Edgewater, Md.</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Aplastic Anemia</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/25/85 to 2/2/85, that (I) (we) last saw the deceased alive on 2/1/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Sylvester W. Coley MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>2/2/85</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E W COLE III</i>			22e. ADDRESS <i>51 FRANKLIN ST ANNAPOLIS MD</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2/7/1985</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Dominic's Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Phila., Penna.</i>			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME <i>Taylor Funeral Chapel</i>			ADDRESS <i>ANNAPOLIS, MD.</i>			25a. DATE REC'D. BY REGISTRAR <i>MAR 11 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Sue Davidson Rose</i>							



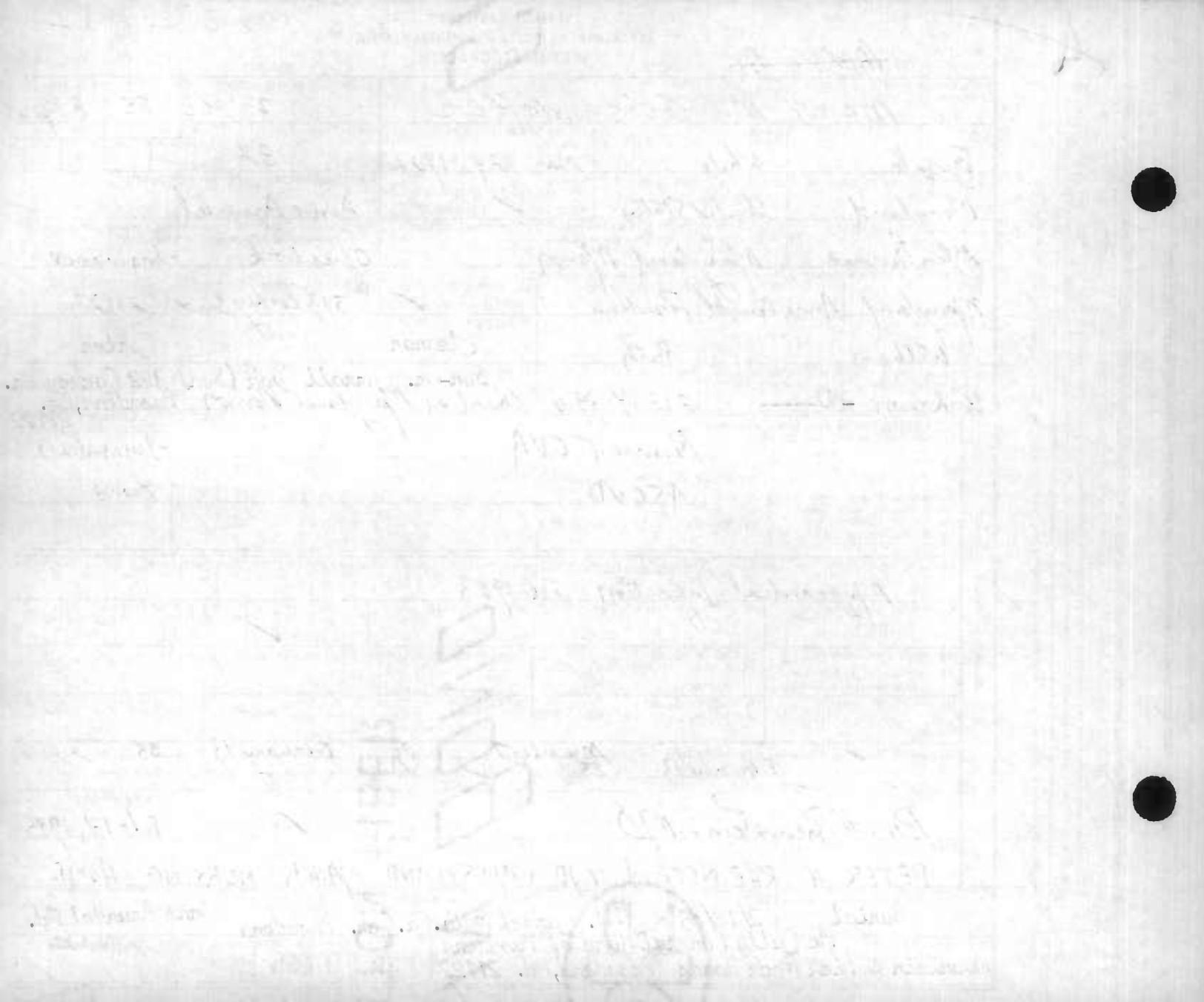
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Medical Examiners.

**IMPORTANT:** If Item 21 is marked or checked, then either a minor injury or other traumatic event (the medical term is "illness") has occurred.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8503391						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR							
MARY M. Geisendaffer						2 13 85			850 PM							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR		8. UNDER 24 HRS				
Female		White		Mar 24 1902			82 yrs.			MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland		United States					Anne Arundel									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			13f. KIND OF BUSINESS OR INDUSTRY			
Beverly Hills		Maryland Manor		Anne Arundel, Maryland			NO			313 Cockey Lane / 21022			Insurance			
13g. STATE		13h. COUNTY		13i. CITY OR TOWN			13j. MOTHER'S MAIDEN NAME			13k. STREET ADDRESS			13l. ZIP CODE			
Maryland		Anne Arundel		Pasadena			Eleanor									
14. FATHER'S NAME		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			17. CAUSE OF DEATH (Enter only one cause per line for 16, 18, and 19.) PART I. DEATH WAS CAUSED BY:			
William				Ruth			Eleanor						Unknown		18. IMMEDIATE CAUSE (a) <u>Recurrent CVA</u>	
19. DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>										Son - Mr. Carroll Cook (Son) 322 Cockey Dr. Chart at Maryland Manor Pasadena, Md.						
20. DUE TO, OR AS A CONSEQUENCE OF (c) _____										Immediate Years						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21h. LOCATION STREET						CITY OR TOWN		COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from <u>December 7, 1983</u> , to <u>February 13, 1985</u> , that (we) last saw the deceased alive on <u>February 12, 1985</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.																
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED						
Peter H. Bernstein, MD										<u>Feb 14, 1985</u>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS														
PETER H. RAINSTEIN, MD		MARYLAND MANOR NURSING HOME														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. STAFF PHYSICIAN <input type="checkbox"/>		23f. DATE REC'D. BY REGISTRAR						
Burial		2/18/85		Mt. Carmel Meth. Ch. Cemetery, Pasadena		Anne Arundel, Md.										
24. FUNERAL DIRECTOR		Mc Cully Funeral Home of Pasadena		ADDRESS		NAME		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR						
				Mountain & Tick Neck Roads Pasadena, Md. 21122				June Davison		FEB 19 1985						

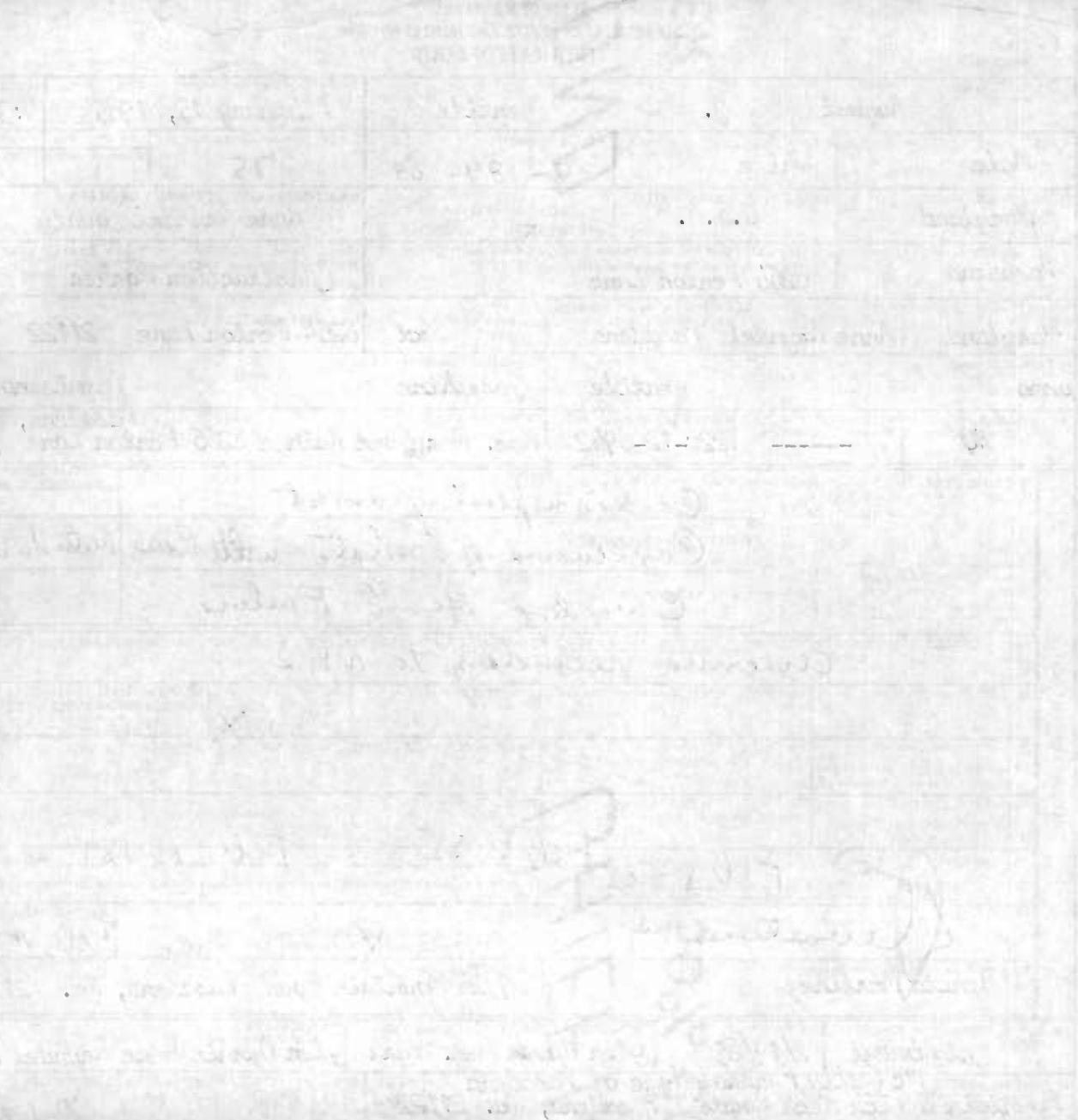


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												03392						
												REG. NO.						
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			August			J.			Gentile			February 15, 1985					4:30 P.M.	
3. SEX <i>Male</i>			4. RACE <i>White</i>			5. DATE OF BIRTH MONTH <i>9</i> DAY <i>29</i> YEAR <i>09</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS.			IF UNDER 1 YEAR		IF UNDER 24 HRS				
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i>			MD.						
10. CITY OR TOWN OF DEATH <i>Pasadena</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOTE: SUCH FACILITY, GIVE STREET ADDRESS) <i>8265 Fenton Lane</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Construction Worker</i>			12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Anne Arundel</i>			13c. CITY OR TOWN <i>Pasadena</i>			14. FATHER'S NAME FIRST <i>Osmo</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Josephine</i>			16. STREET ADDRESS <i>8264 Fenton Lane 21122</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>220-12-6942</i>			17. INFORMANT <i>Mrs. MaryJane Rainze</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Congested respiratory arrest</i>			ADDRESS <i>Pasadena, Md. 8266 Fenton Lane 21122</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) DUE TO, OR AS A CONSEQUENCE OF <i>Carcinoma of Prostate with Bone Metastases</i>			(c) DUE TO, OR AS A CONSEQUENCE OF <i>Congestive Heart Failure</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Anemia secondary to No 2</i>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21g. DATE SIGNED <i>Feb 16-85</i>												
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) did (did not) view the body after death.			22b. SIGNATURE <i>Benito Martinez</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>Feb 16-85</i>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Benito Martinez</i>			22f. ADDRESS <i>29321 Mountain Road Pasadena, Md. 21122</i>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Entombment</i>			23b. DATE <i>2/19/85</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Mem. Park</i>			23d. LOCATION CITY OR TOWN <i>Glen Burnie Anne Arundel Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Mc Cutty Funeral Home of Pasadena</i>			ADDRESS <i>Pasadena, Md. 21122</i>			25a. DATE REC'D. BY REGISTRAR <i>Feb 19 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Levison Pendell</i>									



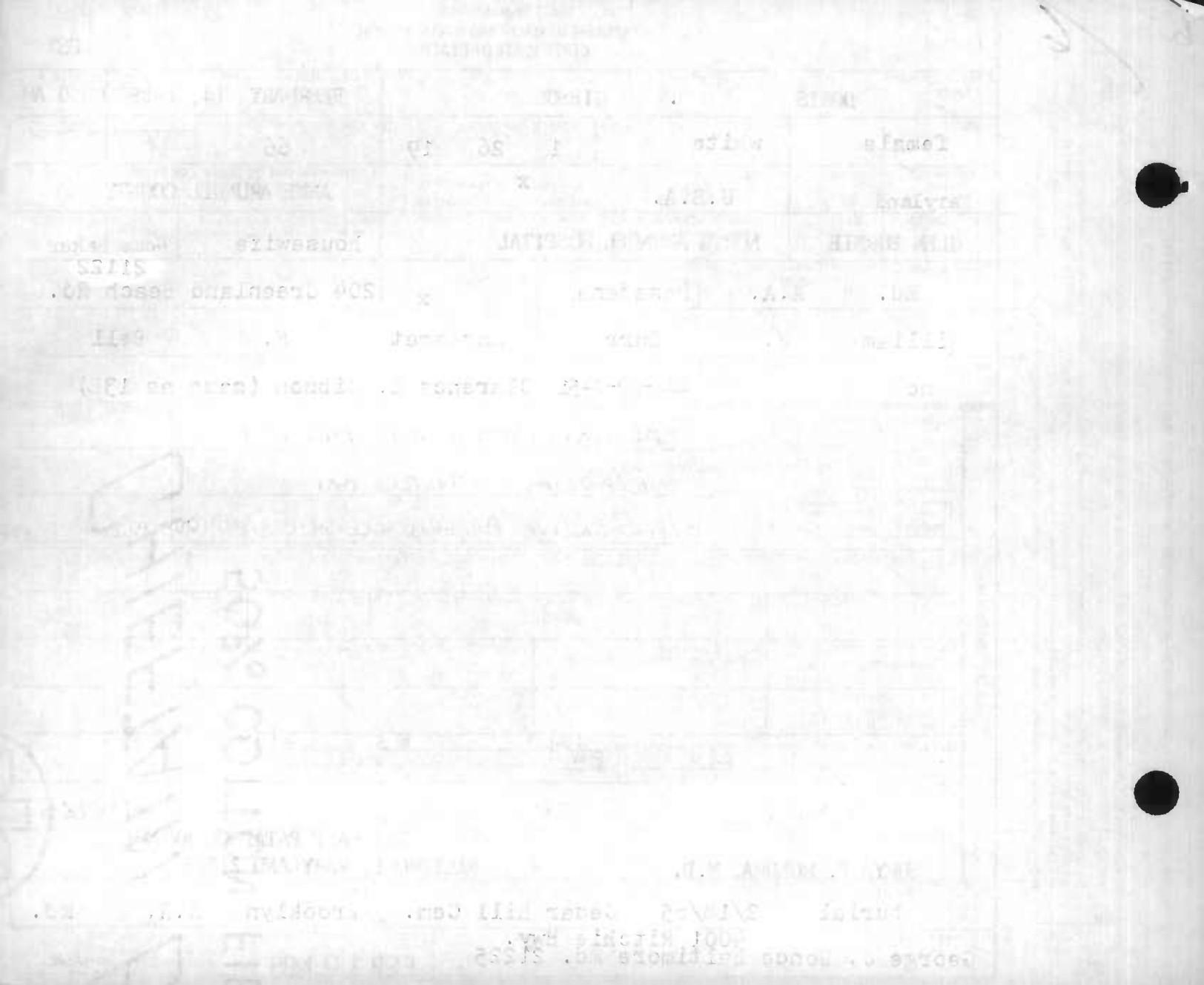
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										03395 EST					
										REG. NO.					
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST DORIS	MIDDLE B.	LAST GIBSON	2a. DATE OF DEATH MONTH FEBRUARY			YEAR 1985	2b. HOUR 0950 AM			
3. SEX female		4. RACE white			5. DATE OF BIRTH MONTH 1 YEAR 26 19			6. AGE (IN YEARS LAST BIRTHDAY) YRS. 66			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY							
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY Home Maker				
13a. STATE Md.		13b. COUNTY A.A.		14c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. STREET ADDRESS 204 Greenland Beach Rd.		21226					
14. FATHER'S NAME FIRST William		MIDDLE F.		LAST Durr		15. MOTHER'S MAIDEN NAME FIRST Margaret		MIDDLE F.		LAST Bell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-09-8451		17. INFORMANT Clarence E. Gibson (same as 13e)		ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARDIOPULMONARY ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION													
		DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.		12/14 1984			19 83			to 2/14 1983							
22b. SIGNATURE <i>Surya P. Mundra</i>		DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/14/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURYA P. MUNDRA, M.D.		22e. ADDRESS 203 EAST PATAPSCO AVENUE BALTIMORE, MARYLAND 21225													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 2/18/85			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cem.			23d. LOCATION CITY OR TOWN Brooklyn			COUNTY A.A.		STATE Md.		
24. FUNERAL DIRECTOR NAME George J. Gonce		4001 Ritchie Hwy Baltimore Md. 21225						25a. DATE REC'D. BY REGISTRAR FEB 19 1985			25b. REGISTRAR'S SIGNATURE Gloria Davidson-Randall				



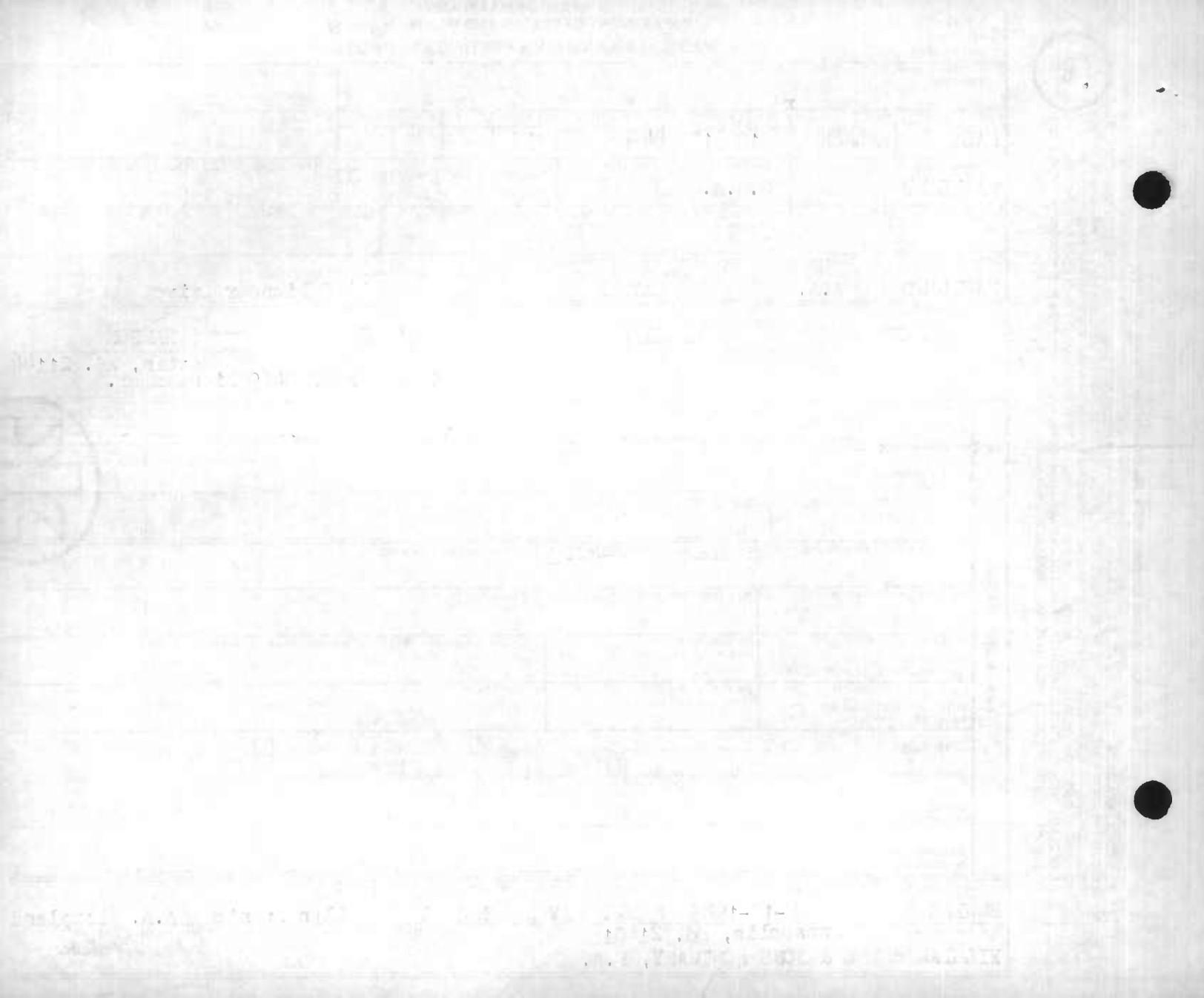
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03394

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
Jomarr					Gilliam	<input type="checkbox"/>	2	8	1985	M
3. SEX	RACE	4. DATE OF BIRTH MONTH DAY YEAR	5. AGE IN YEARS LAST BIRTHDAY	6. IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
MALE	BLACK	10 13 84	3 yrs.			2	8	1985	2:25A	
7a. BIRTHPLACE STATE OR MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County			MD.
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY A.A.	13c. CITY OR TOWN SEVERN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8469 Pioneer Drive	21144			
14. FATHER'S NAME FIRST DAVID		MIDDLE	LAST GILLIAM	15. MOTHER'S MAIDEN NAME FIRST CHANTELL		MIDDLE	LAST RANSOM			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.			17. INFORMANT CHANTELL RANSOM 8469 Pioneer Dr.		ADDRESS Severn, Md. 21144			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Scalds and Submersion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(b) _____ DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 2/8 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject scalped and submerged in water		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY AT HOME, STREET, FACTORY, FARM, ETC. home			21f. LOCATION STREET 8469 Pioneer Dr. Severn, Anne Arundel Co. Md.		CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion										
ACTUAL SIGNATURE <i>Thomas D. Smith</i> TITLE (SPECIFY) M.D. Acting Chief MEDICAL EXAMINER										
DATE SIGNED 2/9/85										
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.			ADDRESS 111 Penn St.		Balto., MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 2-15-1985		23c. NAME OF CEMETERY OR CREMATORIUM GLEN HAIVEN CEMETERY		23d. LOCATION CITY OR TOWN Glen Burnie		COUNTY A.A. Maryland		
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.		ADDRESS Annapolis, Md. 21401		25a. DATE REC'D. BY REGISTRAR FEB 22 1985		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Rendell</i>				



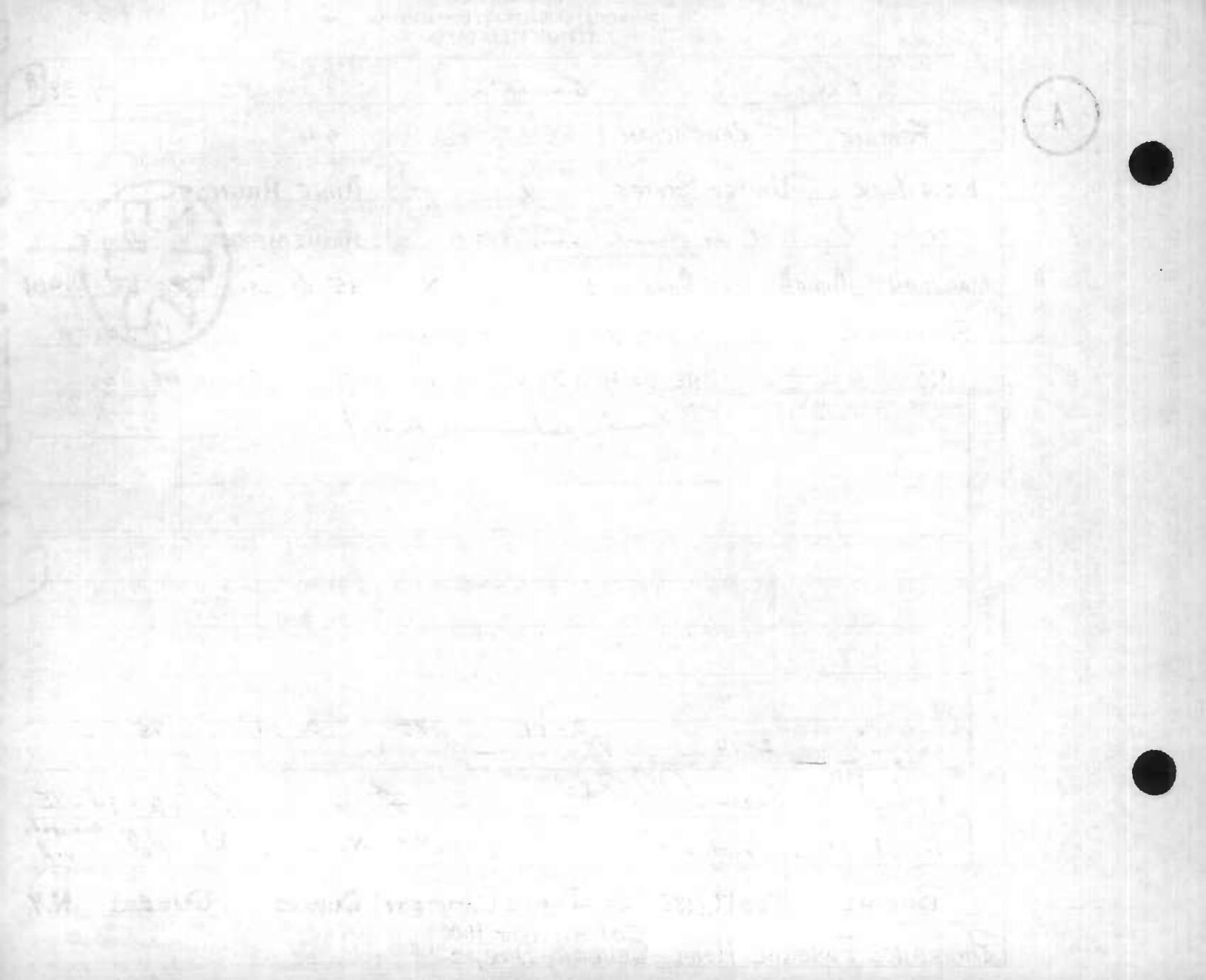
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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03395						
1 - STATE REGISTRAR			1 DATE OF DEATH			MONTH DAY YEAR			26 HOUR							
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH			2b MONTH DAY YEAR			26 HOUR				
Caroline			Granata			2/14/85			9:38 AM							
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE		CAUCASIAN		3 15 80			94 YRS.			MONTHS DAYS		HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH									
New York		United States					Anne Arundel			MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Annapolis, Md.		Anne Arundel Gen. Hosp.						Homemaker			Home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland		Anne Arundel		Annapolis						445 Blossom Tree Dr 21401						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Frederick Carpenter		Kathleen O'Brien														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 113-03-4118D			17. INFORMANT EDNA BENNETT			ADDRESS (SAME AS 13)								
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost																
DUE TO, OR AS A CONSEQUENCE OF (b) { DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (this hospital) attended the deceased from 2-14, 19 85, to 2-14, 19 85, that (we) last saw the deceased alive on 2-14, 19 85, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (will) view the body after death.																
22b. SIGNATURE PID Robert M. Greenfield		22c. DEGREE			ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 2-14-85								
22e. ADDRESS 139 Old Solomons Rd Rd, Annapolis, Md.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE FEB 19, 1985		23c. NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery			23d. LOCATION CITY OR TOWN Queens			23e. COUNTY Queens			STATE N.Y.			
24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME		ADDED 501 Ritchie Hwy SEVERNA PARK, MD			25a. DATE REC'D. BY REGISTRAR FEB 20 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Mandell								



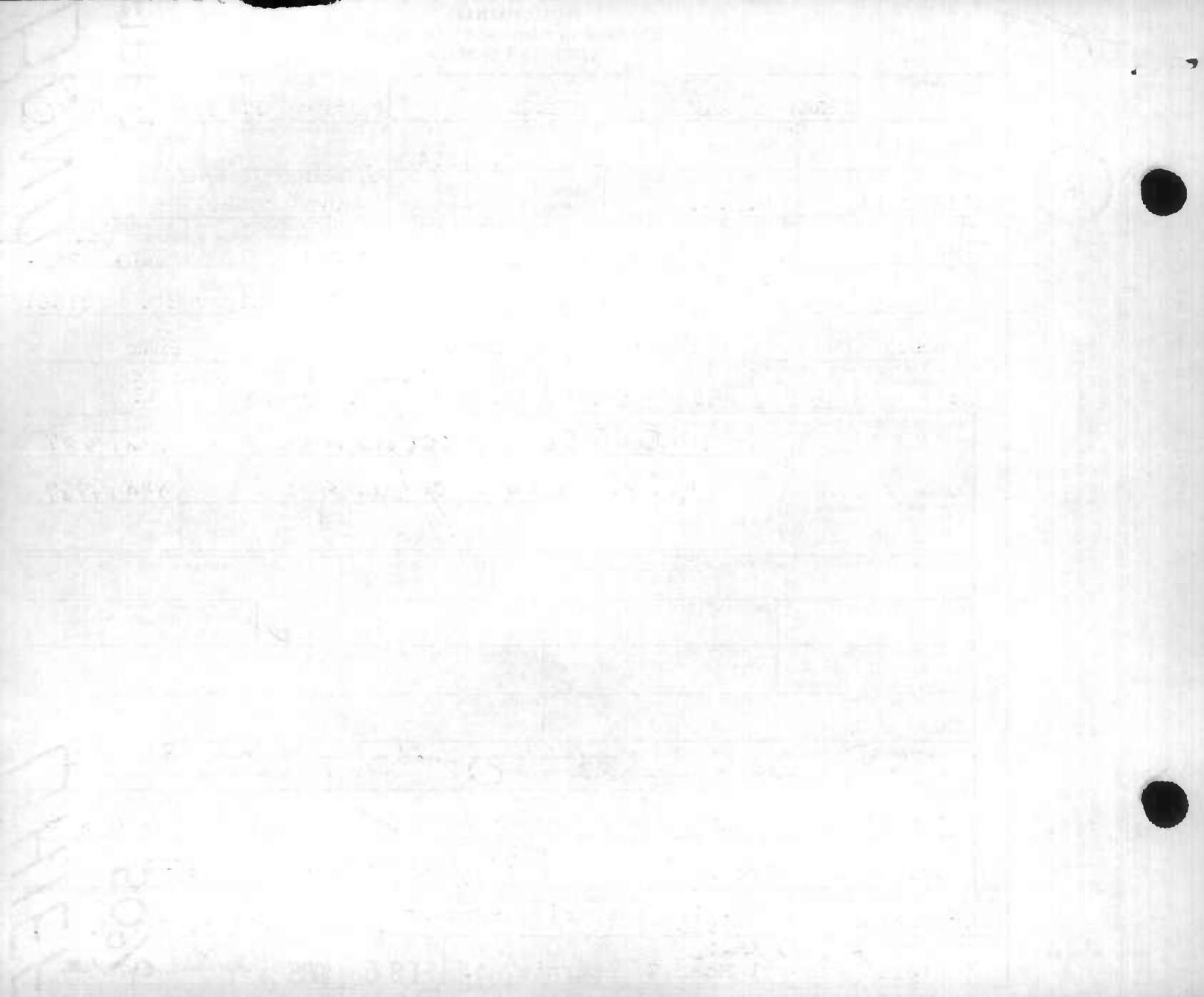
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												0 3 3 9 6							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
BARBARA			ALINE			GREENE						February 3, 1985						1057 PM	
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White			MONTH DAY YEAR						50			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
California			U.S.A.						WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Anne Arundel							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Nurse			12b. KIND OF BUSINESS OR INDUSTRY				
Glen Burnie			101 Juniper Ct.									So. Balto. Gen. Hosp.							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE							
Maryland			Anne Arundel			Glen Burnie			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			101 Juniper Ct. 21061							
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME										
Ernest						Fales			Kathryn										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			(YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			N/A			546-44-8588			(Husband) Mr. Gerald T. Greene			Same as # 13			Mar 1984				
18. CAUSE OF DEATH (Enter only one cause per line for part I, and up to three causes for part II.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												metastatic carcinoma							
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma of lung							
DUE TO, OR AS A CONSEQUENCE OF (c)												Mar 1984							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that (I) this hospital attended the deceased from 11/7/1973 to 10/16/1983, that (I) we last saw the deceased alive on 10/16/1983, and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <i>Colvin C Carter MD</i>												DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/4/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Colvin Carter			22e. ADDRESS 4700 Pennington Ave. (Curtis Bay) Baltimore, Maryland 21226																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Feb 4, 1985			23c. NAME OF CEMETERY OR CREMATORY Security Process Inc.			23d. LOCATION Catonsville, Balto. Md.										
24. FUNERAL DIRECTOR NAME <i>R. H. Singleton</i> Singleton Funeral Home, Glen Burnie, Md.									25a. DATE REC'D. BY REGISTRAR FEB 5 1985			25b. REGISTRAR'S SIGNATURE <i>Juba Davidson-Randall</i>							

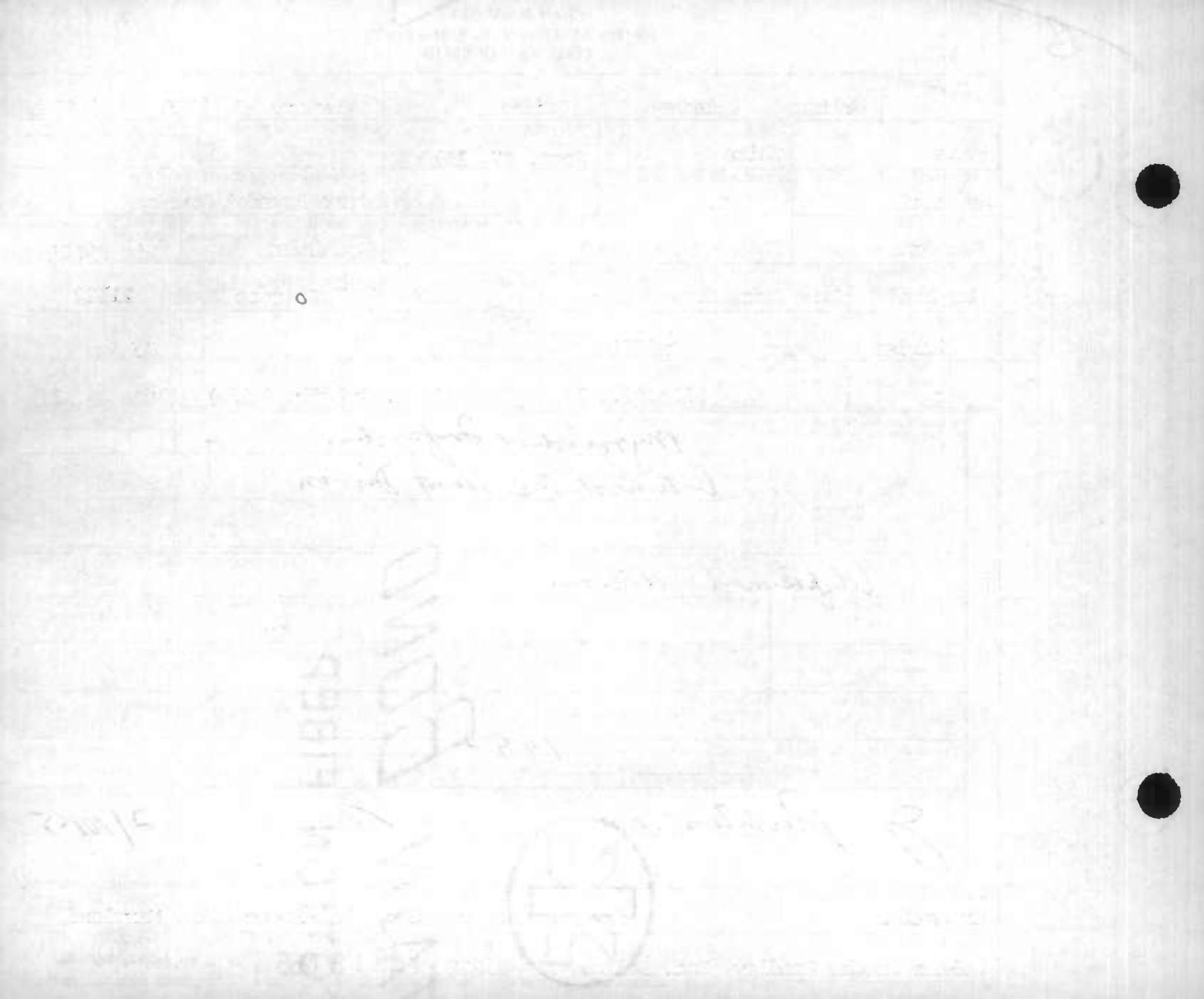


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be called in.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 45 03391							
1 - FOR STATE REGISTRAR			LAST			2a. DATE OF DEATH			MONTH			DAY		YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			2. DATE OF DEATH			MONTH			DAY		YEAR		2b. HOUR			
Walter Harvey Griffin						February 10, 1985										4:45 am			
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH			DAY		YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			
Male			White			Sept. 27, 1910										74 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
New York			U.S.A.									Anne Arundel County MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Pasadena			1869 Patomac Road			Machinist			Shipbuilding										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE							
Maryland			Anne Arundel			Pasadena						1869 Patomac Road 21122							
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
Charles Henry Griffin			Hilda			124.03.8910			Isabelle L. Griffin (Wife)			(Same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mycarditis Infarction</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriovenous fistula</i>																			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriovenous fistula</i>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Alzheimer's disease</i>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from 1982, 19, to 19, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			21/10/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Green Mount Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland										
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc.			ADDRESS Balto., MD 21222			25a. DATE REC'D. BY REGISTRAR FEB 13 1985			25b. REGISTRAR'S SIGNATURE Julie Dawson-Randall										



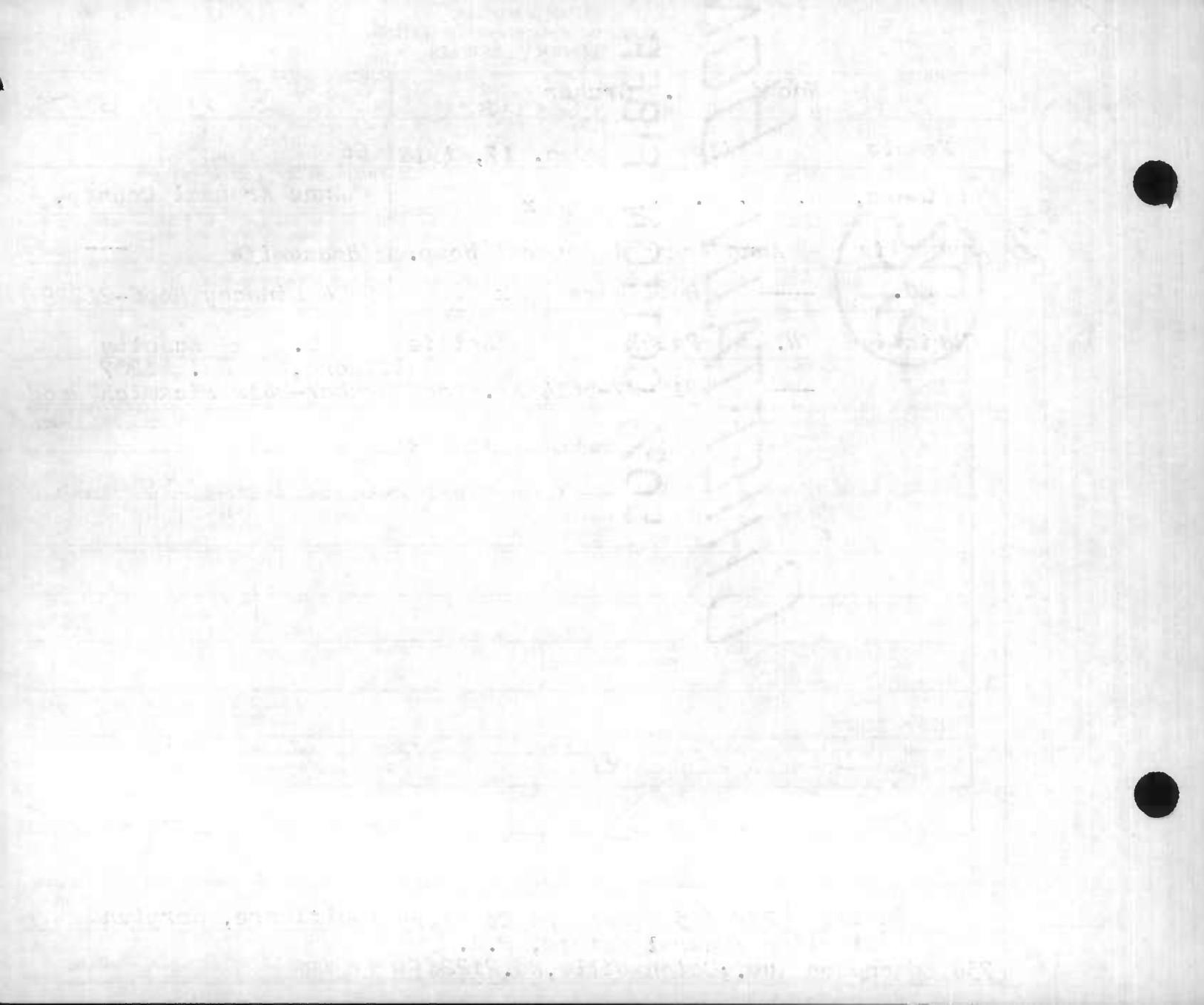
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "showing any injury, or other traumatic event, the medical examiner must be notified at once."

## MEDICAL CERTIFICATION

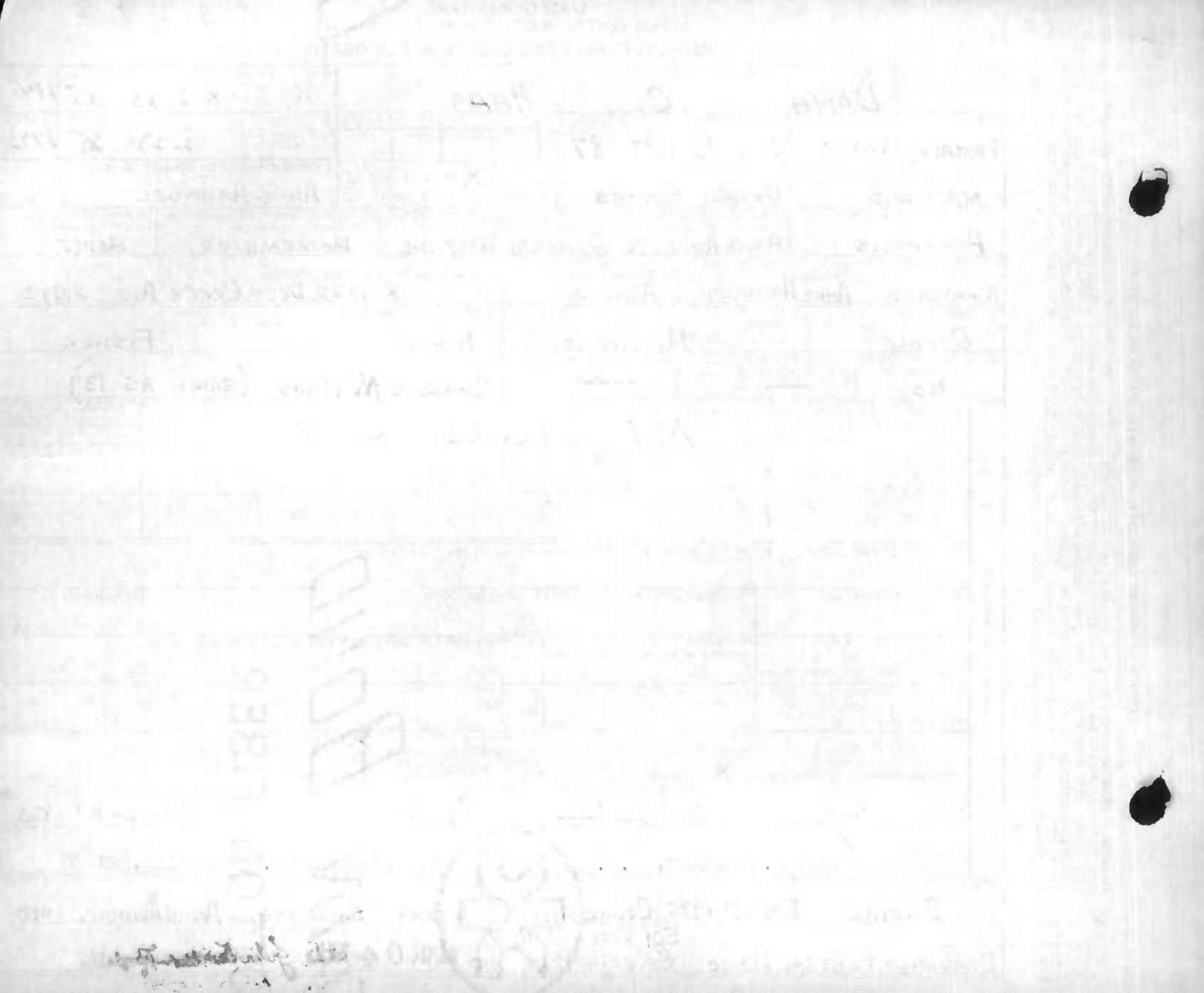
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 3503398						
1 - STATE REGISTRAR		1a. DECEASED NAME (TYPE OR PRINT)		1b. FIRST Naomi MIDDLE R. LAST Gruber		2a. DATE OF DEATH 2-23-85	MONTH	DAY	YEAR	2b. HOUR 5:47 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Dec. DAY 17, YEAR 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66	IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS HOURS 5			
7a. BIRTHPLACE (STATE OR FOREIGN) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.						
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ---						
13a. STATE Md.		13b. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5004 Lindsay Road-21229						
14. FATHER'S NAME FIRST Christian MIDDLE N. LAST Feick		15. MOTHER'S MAIDEN NAME FIRST Mattie MIDDLE C. LAST McNally										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-07-5614		17. INFORMANT Baltimore, ADDRESS Md. 21207		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Intra cranial hemorrhage APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					BETWEEN ONSET AND DEATH 25 to 6 hr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (1) this hospital attended the deceased from 2-23-85 to 2-27-85, that (1) we last saw the deceased alive on 2-23-85, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (1) we did (did not) view the body after death												
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 2-23-85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/26/85		23c. NAME OF CEMETERY OR CREMATORI Western Cemetery		23d. LOCATION CITY OR TOWN Baltimore, COUNTY Maryland STATE						
24. FUNERAL DIRECTOR NAME Sterling Funeral Estate, P.A. ADDRESS 736 Edmondson Ave.; Catonsville, Md. 21228				25a. DATE REC'D. BY REGISTRAR 8 FB 26 1985		25b. REGISTRAR'S SIGNATURE John Pandee						
(VRA 15, 4)												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1 AND 2. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03399			
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>DONA C. HAAS</b>						2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR <b>2 23 1985</b>				2b. HOUR <b>1345 M</b>	
3. SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>Sept</b> DAY <b>22</b> YEAR <b>1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87 yrs.</b>		7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		2c. DATE PRONOUNCED DEAD <b>2 23 1985</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>ARNOLD</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1032 DEEP CREEK AVE 21012</b>					
14. FATHER'S NAME FIRST <b>GEORGE</b>		MIDDLE		LAST <b>HITCHENS</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b>		16. SOCIAL SECURITY NO. <b>—</b>				17. INFORMANT ADDRESS <b>CHARLES M HAAS (SAME AS 13)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MI - cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on <b>Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/></b> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>J. E. Wheeler</b>		TITLE (SPECIFY) <b>M.D.</b>						MEDICAL EXAMINER <b>Jep</b>				DATE SIGNED <b>2-23-85</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>James E. Wheeler, M.D.</b>		ADDRESS <b>910 Primrose Rd. Annapolis, 21403</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb 27, 1985</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Baltimore</b>		COUNTY <b>ANNE ARUNDEL</b>		STATE <b>MD</b>	
24. FUNERAL DIRECTOR NAME <b>BARRANCO FUNERAL HOME</b>		ADDRESS <b>501 RITCHIE HWY.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 04 1985</b>				25b. REGISTRAR'S SIGNATURE <b>Julia [Signature]</b>					
20 DMH - 17 (VR A15 ME (5)) 20M 4/82													



5 5 0 3 4 0 0

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

1 - FOR  
STATE  
REGISTRAR

I. DECEASED NAME			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
BLANCHE			A.		HANSON	FEBRUARY 4, 1985				1:00 PM			
3. SEX	4 RACE	5. DATE OF BIRTH											
Femal	White	MONTH	DAY	YEAR									
7b. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR <input type="checkbox"/>	IF UNDER 24 HRS <input type="checkbox"/>	
MARYLAND		U.S.A										96	YRS
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE		NORTH ARUNDEL HOSPITAL			HOMEMAKER						HOME		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE							
MD.	ANNE ARUNDEL	PASADENA	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>		194 PIKE RD. 21122							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS					
				HALL	UNKNOWN			21122					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No					218-36-9621D					Mr. Marie E. Bone - 194 PIKE RD. - PASADENA, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ASHD													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> { DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Pres Bystrophates</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
21g. I certify that (i) this hospital attended the deceased from <u>2/3/85</u> to <u>11/15/85</u> , 19_____, to <u>2/4/85</u> , 19_____, that (ii) we last saw the deceased alive on <u>19_____</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (ii). I also certify that we viewed the body after death.													
21h. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
JORGE B. RAMIREZ, M.D.								22c. DATE SIGNED					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION							
BURIAL		2-7-85		GARDEN OF FAITH		BALTO., MD							
24. FUNERAL DIRECTOR		NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
		<u>Walter J. Hill - 7529 Harford Rd.</u>						FEB 6 1985		<u>Susan Davidson-Kendall</u>			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be delivered to him as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours of issue with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed.



8081-34-2

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2000 March 2000

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2000 March 2000 2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03401				
1 - FOR STATE REGISTRAR			1. DECEASED NAME FIRST MIDDLE LAST							2a DATE OF DEATH MONTH DAY YEAR		2b HOUR		
			ELIZABETH V. HARMON							02 28 1985		A.M.		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE			WHITE		MONTH DAY YEAR			84		MONTHS DAYS		HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		YRS				
MARYLAND			U.S.A.					ANNE ARUNDEL Co.		MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
ANNAPOLIS			ANNAPOLIS NURSING & Conv. Ctr.							EDUCATOR		PUBLIC SCHOOL		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e STREET ADDRESS / ZIP CODE				
13a STATE MD.			13b COUNTY Annapolis Co.		13c CITY OR TOWN Annapolis			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		300 STATE ST 21403				
14. FATHER'S NAME			FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		
WILLIAM F. HARMON					ELIZABETH H. HEINBACH			No		220368451		AMELIA H. SMITH #13		
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) CROWNRY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE HEART DIS DUE TO, OR AS A CONSEQUENCE OF (c)										1 HR				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CARCINOMA OF BREAST, METASTATIC; CARCINOMA OF Ovary.														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
			P.M. 19											
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET				CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) this hospital attended the deceased from 11-16 1964 to 2-28 1985, that (I) we last saw the deceased alive on 2-25 1985 and that (my) our opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death.														
22b. SIGNATURE			22c. DATE SIGNED											
Edward S Beck MD										3/28/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
Edward S Beck MD			1116 Forest Dr Annapolis MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN		23e. COUNTY			
BURIAL			03-02-1985			CEDAR BLUFF Cem. Annapolis A.A. MD								
24. FUNERAL DIRECTOR NAME			ADDRESS							25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
TAYLOR FUNERAL CHAPEL Annapolis MD										MAR 4 1985		Davidson Rendall		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3), it should be detached for use as the burial-tranit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified before

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. EST			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
JOHN SCOTT HARRINGTON						FEBRUARY 4, 1985				130 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR			
Male		White		MONTH DAY YEAR Sept. 15, 1935		49				IF UNDER 24 HRS			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MONTHS DAYS HOURS MIN.			
New Hampshire		U.S.A.				ANNE ARUNDEL COUNTY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL								12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE			
Maryland		A.A.		Severn						1232 D Severn Rd. 21144			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				FIRST	MIDDLE	LAST		
Leonard W. Harrington					Phyllis M. Tucker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS					
no				Richard Harrington same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Respiratory failure										5 hours			
DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma of lung													
DUE TO, OR AS A CONSEQUENCE OF (c) obstructive jaundice													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 11/11/1985 to 2/4/1985, that (I) (we) last saw the deceased alive on 2/3/1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE James S. Kauppinen										DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RANI S. KARPPINEN, M.D.										22e. ADDRESS 200 HOSPITAL DRIVE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 6 Feb. 85		23c. NAME OF CEMETERY OR CREMATORIAL SECURITY PROCESS			23d. LOCATION CITY OR TOWN Catonsville Balto. MD.		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME James S. Kirkley Glen Burnie MD.										25a. DATE REC'D. BY REGISTRAR FEB 7 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson Kendall	
(VRA 15, 4)													

TYPE OF DOCUMENT

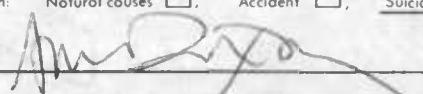
16012020 1200 PM MDT

16012020 1200 PM MDT

16012020 1200 PM MDT



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												0 3 4 0 3		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED			MONTH	DAY	YEAR	2b. HOUR		
HAROLD			T.	HARTLEY	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	28	T 9	85	M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR		
MALE	WHITE	10 1 15	69			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	28	T 9	85	12	P 45 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County			MD.		
10. CITY OR TOWN OF DEATH Severna Park			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) woods-Rt. 2 & Robinson Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Auto Mechanic					
13a. STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Linthicum			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 719 Evelyn Ave. 21090		
14. FATHER'S NAME FIRST Frank			MIDDLE			LAST Hartley			15. MOTHER'S MAIDEN NAME FIRST Myrtle			LAST Unavailable		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 218-10-8166			17. INFORMANT Bonnie McCormick			ADDRESS 21061					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Incised wound of neck</u> DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 2-28- 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject cut self.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) woods			21f. LOCATION STREET Rt. 2 & Robinson Rd., Pasadena, Anne Arundel,			CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Md.		
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)			Ann M. Dixon, M.D.			ADDRESS			DATE SIGNED 3-1-85					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 3/6/85			23c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery			23d. LOCATION CITY OR TOWN Salisbury			COUNTY Wicomico		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.			ADDRESS 4107 Wilkens Ave.			25a. DATE REC'D. BY REGISTRAR MAR 4 1985			25b. REGISTRAR'S SIGNATURE 					
DMMH - 17 (VR A15 ME (5))														

COLONIAL MINT



**Medical Examiner Notified & Released**

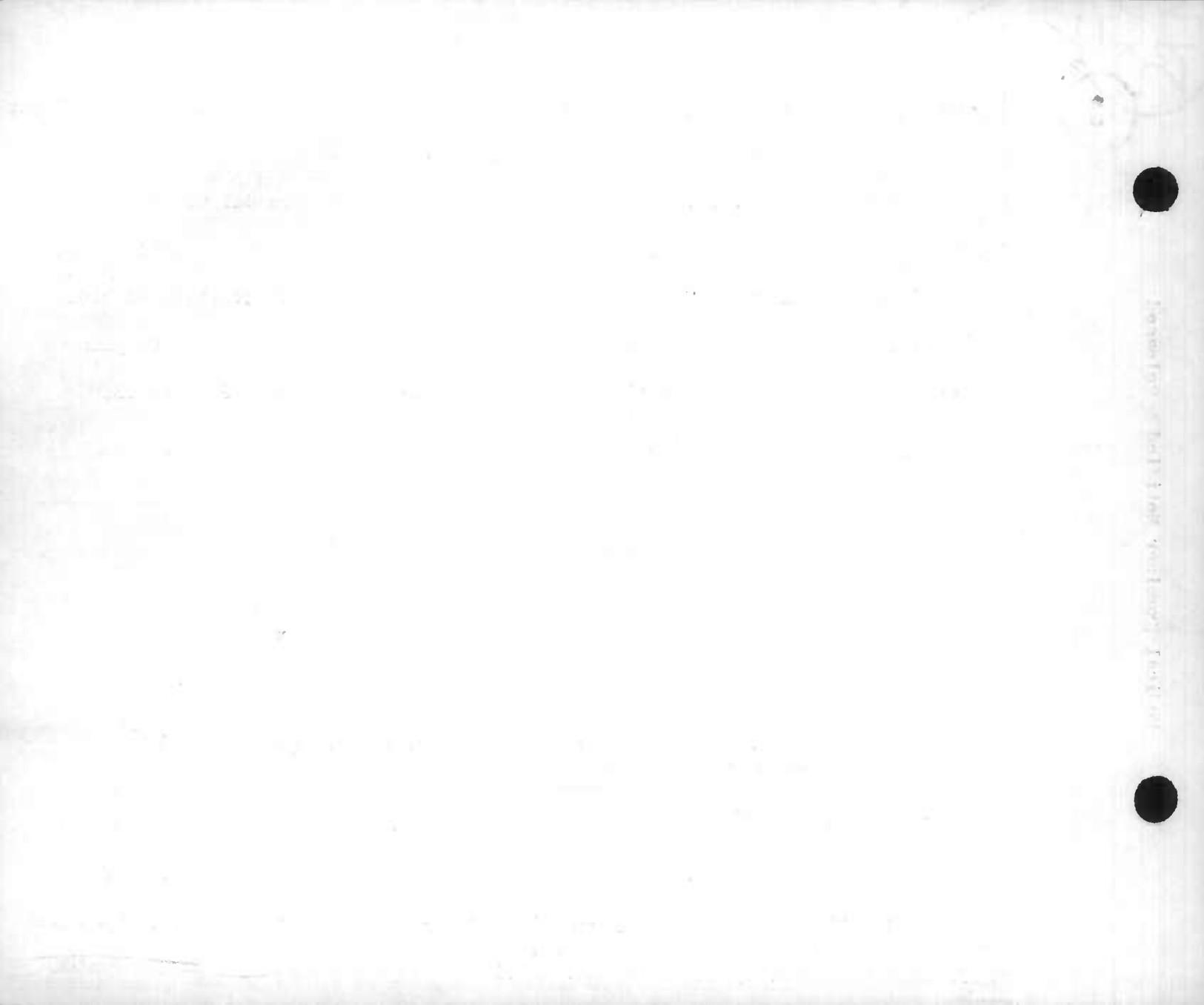
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 4 & 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 is checked, attach a copy of the medical certificate to this page.

**MEDICAL CERTIFICATION**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 5 0 3 4 0 4			
1 - FOR STATE REGISTRAR		I. DECEASED NAME FIRST MIDDLE LAST				2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
		Ruby M. Hays				02		25	1985	10:30 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		01 28 1912		73		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia		U.S.A.						Anne Arundel County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Edgewater		1713 Forestville Road				Supervisor		Raleigh Haber-		dasher			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		Anne Arundel		Edgewater		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1713 Forestville Road 21037					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
		Walter		Moore	FIRST	Fonda							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		265-14-1014		Cecil C. Hays (Husband)		Same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i>													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)									
21d. INJURY OCCURRED <small>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/></small>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>10 33</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>7/1</i> , 19 <i>85</i> , to <i>8/24</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE <i>H. Goldstein</i> DEGREE													
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. ADDRESS Howard D. Goldstein, M.D. 205 Ridgely Ave. Annapolis, Md. 21401				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/28/85		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		23d. LOCATION CITY OR TOWN Suitland		COUNTY P.G. Maryland		STATE			
24. FUNERAL DIRECTOR <small>NAME</small> Francis Gatsch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781						25a. DATE REC'D. BY REGISTRAR FEB 28 1985		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Pendleton</i>					
DHMH - 16 50M 4/B3 (VRA 15, 4)													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 03405				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR		
Anita Louise Hedgecoth						February 1, 1985						8:30 A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			White			Sept. 18, 1949			35			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
Maryland			USA						Anne Arundel			MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Annapolis			Anne Arundel General Hospital										Housewife	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Md			AA		Glen Burnie					1220 Cathedral Drive, 21061				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
			Turner	W.	Smith				Helen	L.	Church			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			217-52-4356			Douglas Smith, 236 Wood Hill Dr. Apt.D			Glen Burnie, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock &amp; brain death</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>cardiopulmonary arrest</u> <u>24 hrs</u>														
(c) <u>Sugars - grand mal</u> <u>chronic</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Depression</u> <u>chronic Sugars disorder</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (1) this hospital attended the deceased from <u>1/31/85</u> , to <u>2/1/85</u> , to <u>1985</u> , that (1) (we) lost saw the deceased alive on <u>2/1/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.														
22b. SIGNATURE <u>Joseph N. Friend</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>2/1/85</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph N. Friend, M.D.			22e. ADDRESS 205 Ridgely Ave., Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 4 Feb. 1985			23c. NAME OF CEMETERY OR CREMATORIAL Emmanuel Church Cem.			23d. LOCATION CITY OR TOWN Huntington, Calvert, Md.			COUNTY	STATE	
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Md.			25a. DATE REC'D. BY REGISTRAR FEB 7 1985			25b. REGISTRAR'S SIGNATURE <u>John Anderson Pendell</u>								
BP _____														
DHMH - 16 50M 1/B1 (VRA 15, 4)														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 85 03406			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR A M			
			GEORGE H. HEINLEIN, JR.						2-22-85			2 A M			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			
MALE			WHITE			6 8 23			61 YRS.			IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH R ANNE ARUNDEL CO.			
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 325 W. RIVERVIEW RD.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LETTER CARRIER POST OFFICE			12b. KIND OF BUSINESS OR INDUSTRY 21225						
13a. STATE MD.			13b. COUNTY A A Co.			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 325 W. RIVERVIEW RD.			
14. FATHER'S NAME GEORGE H HEINLEIN, SR.						15. MOTHER'S MAIDEN NAME SOPHIA B.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW II			17. INFORMANT SYLVIA R. HEINLEIN			ADDRESS SAME AS 13			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 1a) <i>A SAD - Cancer respiratory</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>14-11</i> , 19 <i>85</i> , to <i>12</i> , 19 <i>85</i> , that (we) last saw the deceased alive on <i>17</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>G. Alzert.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 21225						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. LAWRENCE F. AWALT			22e. ADDRESS 3001 S. HANOVER ST. BALTO.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2-25-85			23c. NAME OF CEMETERY OR CREMATORIAL CROWNSVILLE VET.			23d. LOCATION CITY OR TOWN CROWNSVILLE, A A Co.			COUNTY	STATE		
24. FUNERAL DIRECTOR NAME McCULLY FUNERAL HOMES			ADDRESS 237 E. PATAPSCO AVE			25a. DATE REC'D. BY REGISTRAR EB 25 1985			25b. REGISTRAR'S SIGNATURE John Davidson Pendell						

28-68-8 ST 413413H H 329030

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be forwarded to the funeral director. Page 3 should be detached for use of the burial/transit permit. Then please remove carbon paper. Page 4 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

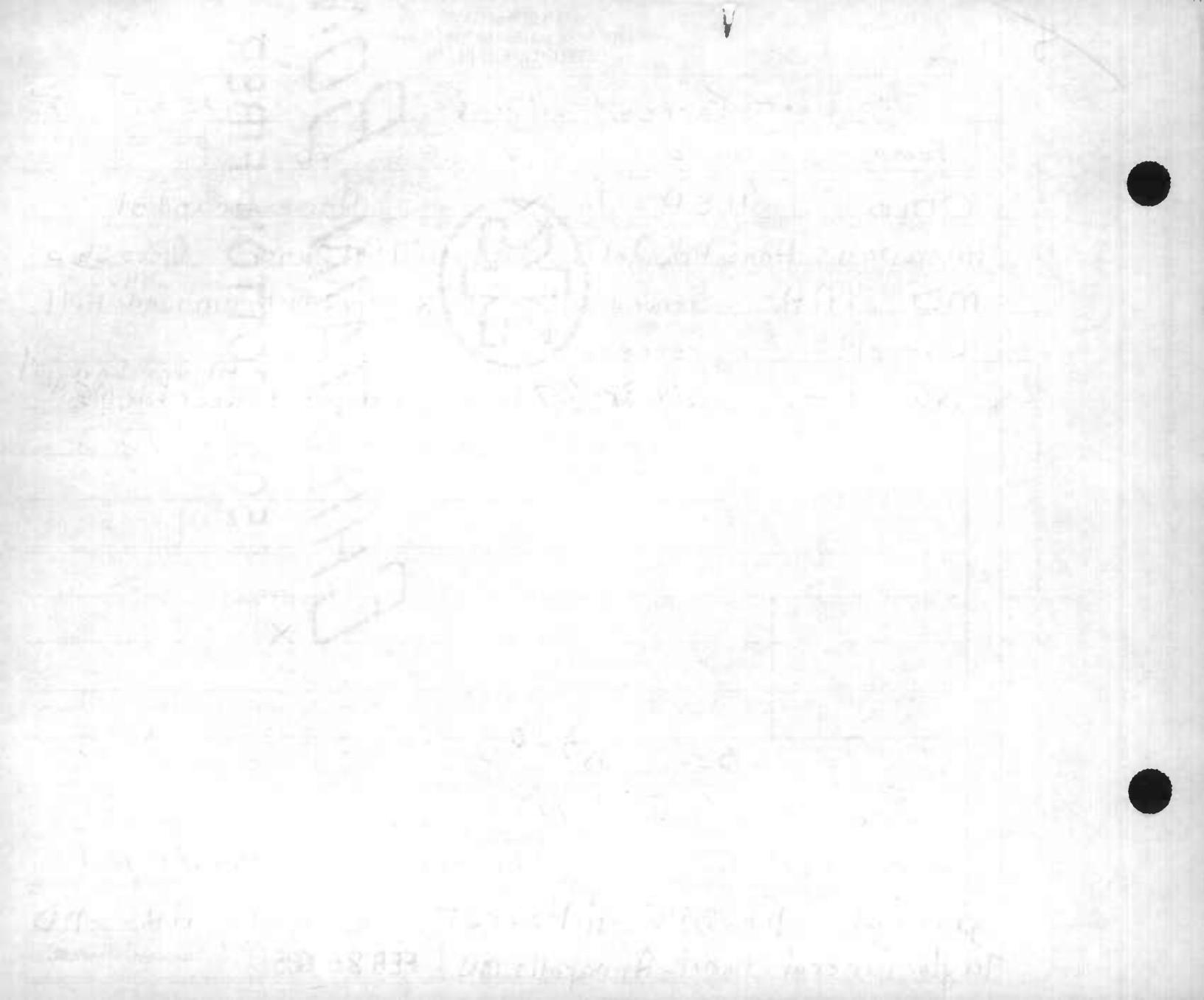
IMPORTANT: If Item 21 is marked or Item 16 shows any injury or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 03401

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Margaret Ferree Hendricks						2	25	85		120 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR				
FEMALE		WHITE		MONTH	DAY	YEAR	75		MONTHS	DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 24 HRS				
Ohio		USA				Anne Arundel			YRS	MONTHS	HOURS	MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis		Anne Arundel General Hospital Ret. Owner							Dress Shop				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		ZIP CODE		
MD		AA		Sherwood Forest		X			702 N Robinhood Hill		21405		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Carroll				Ferree									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
NO		-		214-38-8137 Dudley F. Hendricks-Deer Isle, ME 04621			Algrims Inn						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Metastatic Ovarian Carcinoma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b)													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED  WHITE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (1) this hospital attended the deceased from <u>2/25</u> , 19 <u>85</u> , to <u>2/25</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) we did not view the body after death.													
22b. SIGNATURE E.W. COLE III		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/25/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 51 FRANKLIN ST ANNAPL. MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Feb. 27, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest			23d. LOCATION CITY OR TOWN Annapolis			23e. COUNT A.A.			
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD		ADDRESS		25a. DATE REC'D. BY REGISTRAR FEB 26 1985			25b. REGISTRAR'S SIGNATURE Julie L. Anderson-Pendell						



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 03408	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Mary Agnes Herron						Feb. 15, 1985				4:20 P.M.			
3. SEX			4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)								
F			CAUCASIAN	Oct 27 1902	82								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Annapolis Md			U.S.A.			Ann Arundel							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis Md			Bay Manor Nursing Home			Housewife			HOME				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS			21146				
Md.			A.A.	SEVERNA PARK		177 Robinson Landing Rd							
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
William Frank JEFFERSON Franklin Thomas			mary VIRGINIA Tayman										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.	17. INFORMANT						ADDRESS			
NO			214-65-1363A	MILDRED DAVENPORT			(SAME AS 13)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest,												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause, lost. (b) Sepsis (c) Newland Park in sepsis													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2.15-1983 to 2.15-1985, that (I) (we) last saw the deceased alive on 1.31.1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE DR. C. V. CYRIAC			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2.15-85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. C. V. CYRIAC			22e. ADDRESS 14 WELLHAM AVE (NW) SUITE 101 GLENBURNIE MD 21021001										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE FEB. 19, 1985	23c. NAME OF CEMETERY OR CREMATORIAL GLEN HAVEN CEMETERY			23d. LOCATION CITY OR TOWN GLEN BURNIE ANN ARUNDEL MD.			COUNTY STATE			
24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR 1081 RITCHIE HWY. MARCH 20 1985			25b. REGISTRAR'S SIGNATURE							

A

5000 ft above sea level - 2000 ft below

5000 ft above sea level - 1000 ft below

5000 ft above sea level - 1000 ft below

5000 ft above sea level - 1000 ft below

5000 ft above sea level - 1000 ft below

(5000 ft) - 1000 ft below

5000 ft above sea level - 1000 ft below

5000 ft above sea level - 1000 ft below

5000 ft above sea level - 1000 ft below

5000 ft above sea level - 1000 ft below

5000 ft above sea level - 1000 ft below

5000 ft above sea level - 1000 ft below

5000 ft above sea level - 1000 ft below

5000 ft above sea level - 1000 ft below

5000 ft above sea level - 1000 ft below

5000 ft above sea level - 1000 ft below

5000 ft above sea level - 1000 ft below

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1-2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1A. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 03409		
1. DECEASED NAME (TYPE OR PRINT)			FIRST Milton			MIDDLE Alves			LAST Hewitt			2a. DATE KNOWN EST. DEATH MATED <input checked="" type="checkbox"/> XX MONTH FEB 13, 1985 DAY 19 YEAR 1985	2b. HOUR 9:31 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH feb. DAY 21, 1944 YEAR 1944		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. HOURS		2c. DATE PRONOUNCED DEAD FEB 13, 1985		2d. HOUR 9:31 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> X NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.								
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronics			12b. KIND OF BUSINESS OR INDUSTRY BALT. AVIONICS CORP.		
13a. STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN Millersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X		13e. STREET ADDRESS 498 Chalet West		21108				
14. FATHER'S NAME FIRST CHARLES MIDDLE KENNETH LAST HEWITT			15. MOTHER'S MAIDEN NAME FIRST CORA MIDDLE LAST ALVES											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES VIETNAM			16b. SOCIAL SECURITY NO. 458.64.6451						17. INFORMANT (WIFE) Marilyn Regina Hewitt Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. 19 MONTH DAY 19 P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> X, Inspection <input type="checkbox"/> X, Inquiry <input type="checkbox"/> X, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> X, Accident <input type="checkbox"/> X, Suicide <input type="checkbox"/> X, Homicide <input type="checkbox"/> X, Undetermined manner <input type="checkbox"/> X.														
TITLE (SPECIFY) <i>Dennis F. Smyth, M.D.</i>														
EXAMINER'S NAME (TYPE OR PRINT)			Dennis F. Smyth, M.D., ADDRESS 111 Penn St., Balto., Md. 21201						DATE SIGNED 2-14-85					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE FEB. 18, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Our Lady of Fields Cem.			23d. LOCATION CITY OR TOWN Millersville					
24. FUNERAL DIRECTOR NAME <i>H. Oliver</i> ADDRESS <i>Singleton Funeral Home Glen Burnie, Md. 21061</i>									23e. DATE REC'D. BY REGISTRAR FEB 19 1985	23f. REGISTRAR'S SIGNATURE <i>Randall</i>				
25M		BP		25M		25M		25M		25M				
DHMH - 17		(VR A15 ME (5))												

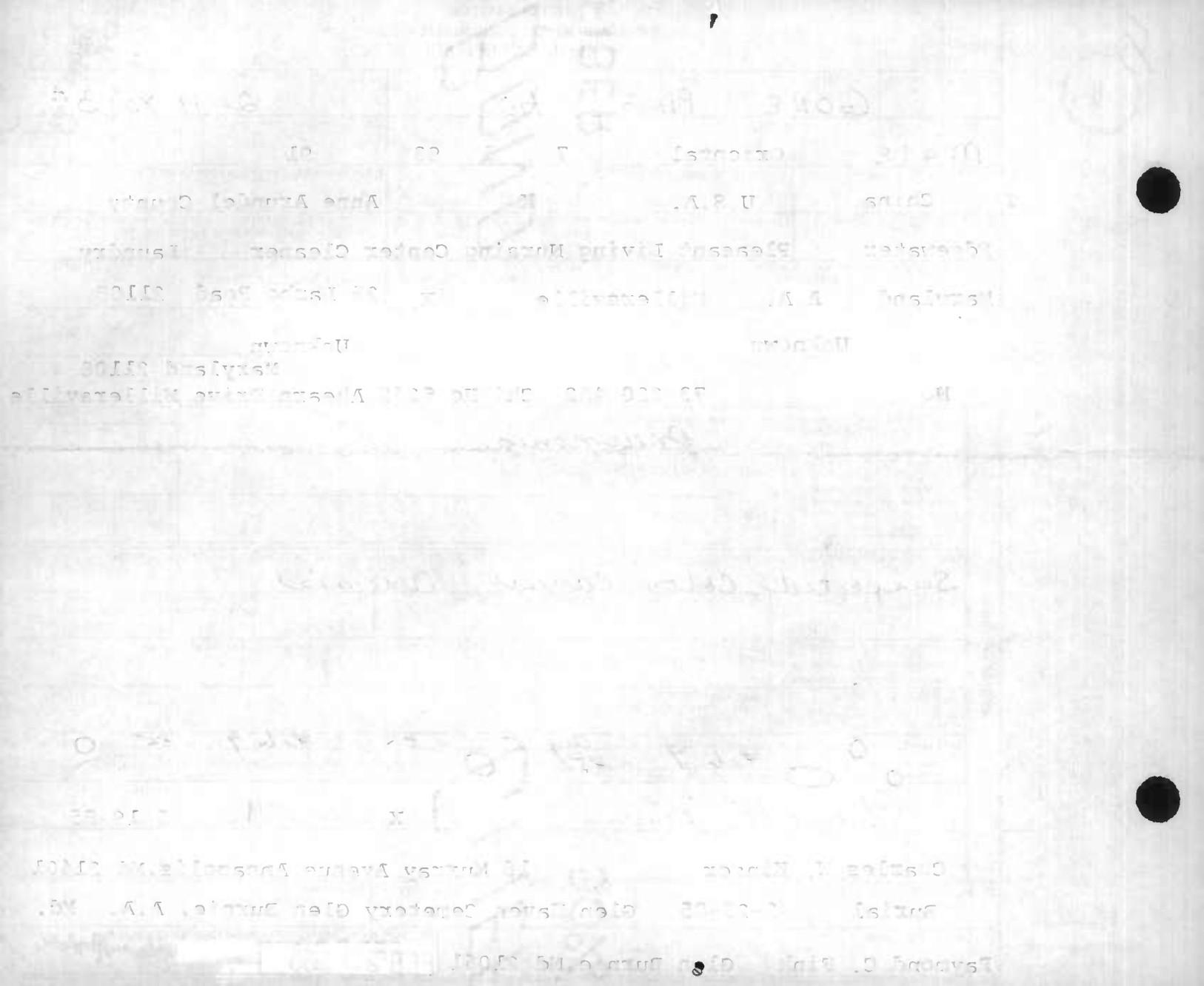


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5 0 3 4 1 0	
											REG. NO.		
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2d. HOUR	
			<b>GONE PING HO</b>						2 19 85			3 <sup>4</sup> M	
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
MALE		Oriental		7 5 93			91 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
China		U.S.A.					Anne Arundel County			MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Edgewater		Pleasant Living Nursing Center Cleaner										12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		A.A.		Millersville				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		26 Larbo Road 21108			
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE LAST			
Unknown							Unknown			Maryland 21108			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		73-220-482		Chi Ho 8265 Ahearn Drive Millersville									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF { (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Suspected Colon Cancer, Anemia</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 5</u> , 19 <u>83</u> , to <u>Feb. 7</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>Feb. 7</u> , 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Charles W. Kinzer</u>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>2-19-85</u>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS											
Charles W. Kinzer		16 Murray Avenue Annapolis, Md. 21401											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN COUNTY			24. FUNERAL DIRECTOR NAME			
Burial		2-25-85		Glen Haven Cemetery			Glen Burnie, A.A. Md.			Raymond C. Fink			
24. FUNERAL DIRECTOR NAME		ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRATION SIGNATURE		
Raymond C. Fink		Glen Burnie, Md. 21061						FEB 20 1985			Julie Gardner Mandell		

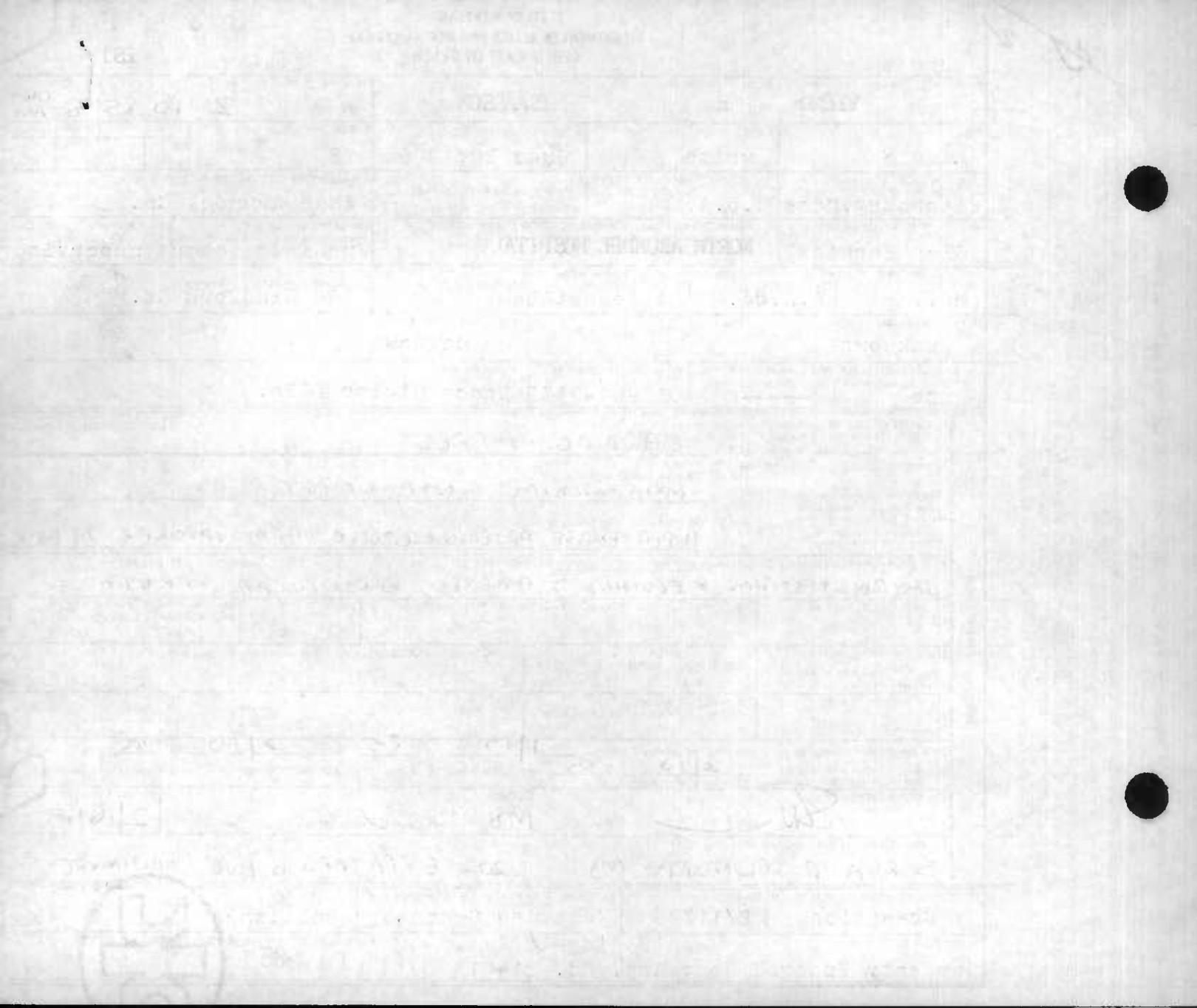


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tombstone permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. EST.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
VIENO E ISAACSON						2b. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female			white			MONTH DAY YEAR			78						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Fitchburg, Mass			U.S.A.									Anne Arundel Co.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE OF FACILITY, ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Glen Burnie			NORTH ARUNDEL HOSPITAL			13a. STATE Md..			13b. COUNTY A.A.C.O.			13c. STREET ADDRESS / ZIP CODE 300 Windfern Ct. 21108			
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST			
unknown						unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
NO			018-01-3475			Nancy Giuler #13e.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b), MYOCARDIAL INFARCTION															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
DUE TO, OR AS A CONSEQUENCE OF (c), HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
GASTROINTESTINAL BLEEDING, DIABETES, VENTRICULAR ARRHYTHMIA															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 117 19 85 to 210 19 85, that (I) (we) last saw the deceased alive on 210 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			22c. DEGREE			MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			203 E PATAPSCO AVE BALTIMORE 21226									
SURYA P. MUNDRA MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE	
Cremation			2/11/85			Westview Crematory			Baltimore			Md.			
24. FUNERAL DIRECTOR NAME			12 Ridgeley Ave. ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Hardesty Funeral Home Ann. Md. 21401						FEB 11 1985									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

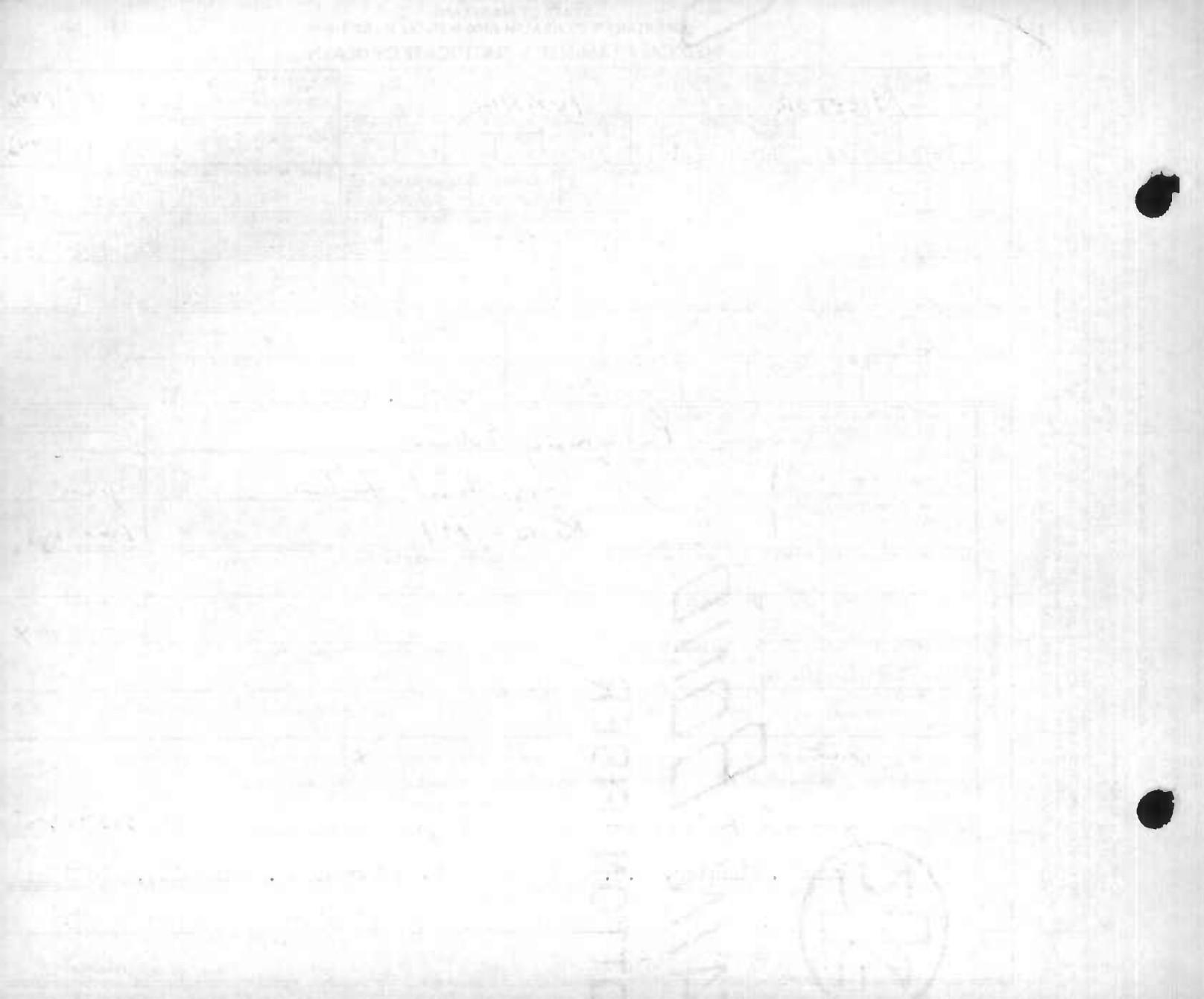
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8503412				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Dolores			T.		Itzkowitz	2 24 85						9:50 pm		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White		11 16 45		39			MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			U.S.A.				Anne Arundel County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Brooklyn			208 W. Edgevale Rd.		Housewife									
13a. STATE Md.			13b. COUNTY A.A.		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 208 W. Edgevale Rd.				
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST		
Paul					Marks		Theresa					Abramski		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No			21444 5684		Kenneth J. Itzkowitz (same as 13e)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
METASTATIC SQUAMOUS CELL CARCINOMA OF NASOPHARYNX														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) _____ DUE TO, OR AS A CONSEQUENCE OF														
(c) _____ DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>FEB 84</u> , to <u>FEB 85</u> , 19 <u>84</u> , to <u>85</u> , that (I) <u>saw the deceased alive on</u> <u>FEB 85</u> , 19 <u>85</u> , and that in my ( <u>I</u> ) opinion death occurred on the date and hour and from the causes stated above, ( <u>I</u> ) <u>we</u> <u>did</u> <u>not</u> <u>view</u> <u>the body</u> <u>after</u> <u>death</u> .														
22b. SIGNATURE <u>Hector Silva</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>2/25/85</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Hector Silva</u>			22e. ADDRESS UMCC 22 S Greene St Balto, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2 27 85		23c. NAME OF CEMETERY OR CREMATORIAL Holy Cross Cem.		23d. LOCATION CITY OR TOWN Brooklyn			COUNTY AA	STATE Md.			
24. FUNERAL DIRECTOR NAME George Goncze			ADDRESS 4001 Ritchie Hwy Balto Md		21225		25a. DATE REC'D. BY REGISTRAR FEB 26 1985			25b. REGISTRAR'S SIGNATURE <u>Juka Davidson Pendall</u>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												0 3 4 1 3		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR		
<i>NICEFOR</i>					<i>IVANAC</i>	<input type="checkbox"/>			2	23	1985	0846 M		
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	7 IF UNDER 1 YR. MONTHS DAYS	8 IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR		
Male	White	March 12, 1913	71 yrs.			<input checked="" type="checkbox"/>			2	23	1985	0842 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Yugoslavia		USA						Anne Arundel County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Glen Burnie		North Arundel Hospital			Warehouseman			Calvert Dist.						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		12061				
Maryland		AA		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		102 Woods Avenue						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
Jacov				Ivanac		Matija				N/A				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
		065-18-4493			Evelyn M. Ivanac, Same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Cong. Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Recent MI</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												years 1 mo ago		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <i>James E. Wheeler</i>		TITLE (SPECIFY) M.D.			MEDICAL EXAMINER <i>Drs.</i>			DATE SIGNED <i>2-23-85</i>						
EXAMINER'S NAME (TYPE OR PRINT)		James E. Wheeler, M.D.			ADDRESS 910 Primrose Rd. Annapolis, 21403									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE				
Burial		Feb. 26, 85		Meadowridge Mem. Park			Elkridge		Howard	MD				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
James S. Kirkley		Glen Burnie, MD			FEB 26 1985			<i>J. S. Kirkley - Pendell</i>						



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial and Mental Hygiene form. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

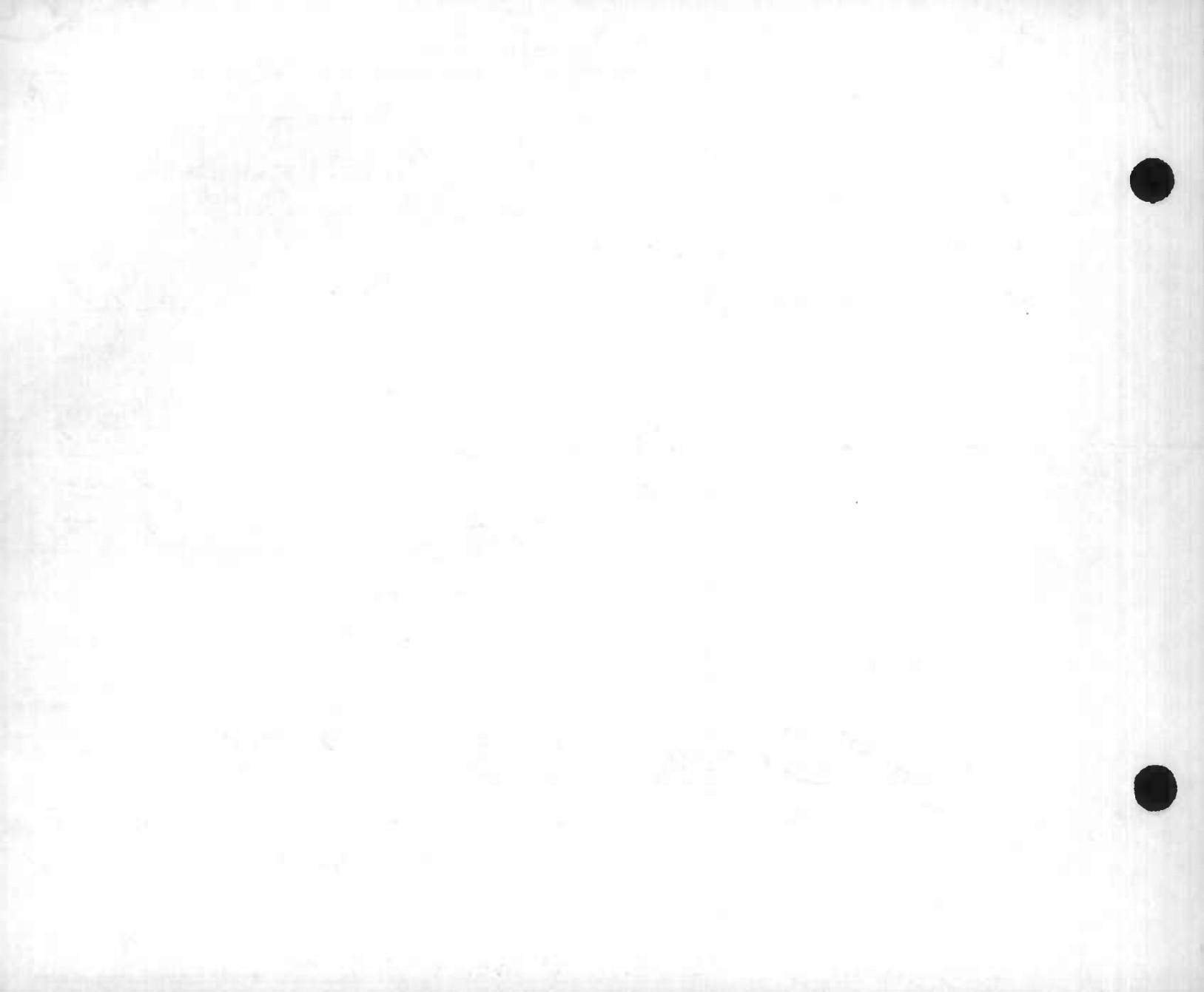
**IMPORTANT:** If item 2 is marked or item 18 shows any injury, or other traumatic event, the medicodexaminer must be notified.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

03414

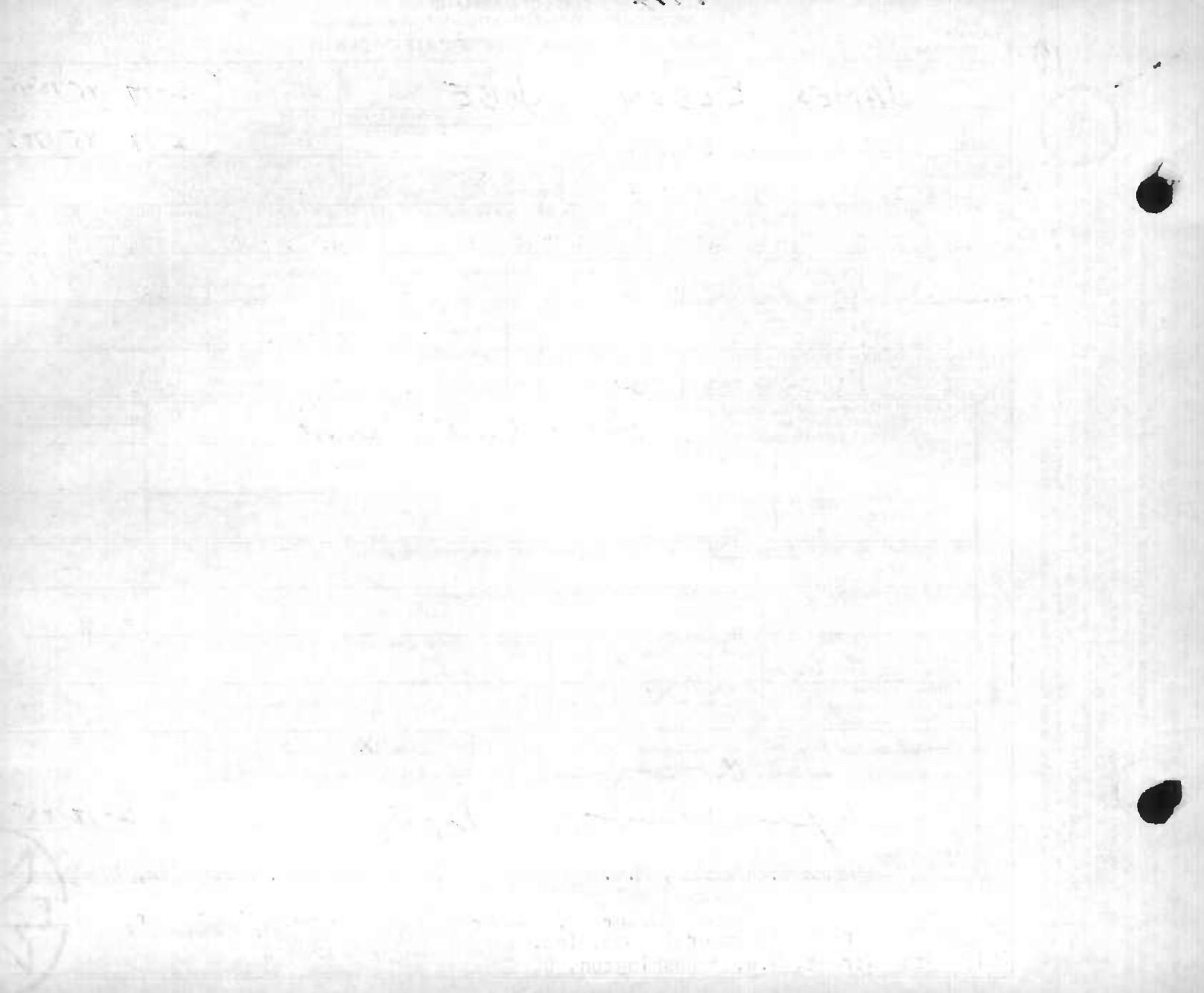
REG NO

1. DECEASED NAME [TYPE OR PRINT] <b>MARTHA JETER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 5 85</b>	2b. HOUR <b>5:30 P.M.</b>
3. SEX <b>Female</b>	4 RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 30 15</b>	6. AGE [IN YEARS LAST BIRTHDAY] <b>69</b>	If Under 1 Year MONTHS DAYS YRS.
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY] <b>N. Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County, Md.</b>	
10. CITY OR TOWN OF DEATH <b>Pasadena</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7873 Solley Road</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13. RESIDENCE [IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION] 13a. STATE <b>Maryland</b>			13b. COUNTY <b>AnneArundel</b>	13c. CITY OR TOWN <b>Pasadena</b>
14. FATHER'S NAME FIRST <b>Lester</b>			MIDDLE <b>Brown</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Ella</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-26-1007</b>	17. INFORMANT <b>K.B. Jeter</b>	ADDRESS <b>7873 Solley Road</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Caduceus Respiratory</i>				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCUO</i>				
DUE TO, OR AS A CONSEQUENCE OF (c) <i>CVA</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o).				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6/28/78</u> , 19 <u>78</u> , to <u>2/5/85</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>2/10/85</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I/we) (did) <input type="checkbox"/> (did not) view the body after death.				
22b. SIGNATURE <i>C. J. Folken</i>			DEGREE <i>M.D.</i>	22c. DATE SIGNED <b>2/5/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Folken</b>		22e. ADDRESS <i>4141 Mt. Rd., Pasadena, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL [TYPE OR PRINT] <b>BURIAL</b>	23b. DATE <b>2/8/85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mount Auburn Cem.</b>	23d. LOCATION CITY OR TOWN <b>Baltimore</b>	23e. COUNTY <b>Md.</b>
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>			25a. DATE REC'D. BY REGISTRATION CLERK FEB 6 1985	25b. SIGNATURE <i>John J. ...</i>
ADDRESS <b>1101 E. North Ave.</b>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THESE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR CUP FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 03415			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR			
			<b>JAMES ELDON JOBE</b>						<input checked="" type="checkbox"/> MONTH DAY YEAR 2-17 1985			1545 M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2-17 1985		2d. HOUR 1703	
MALE		CAUCASIAN		MARCH 3 1931		53 YRS.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		9. BALTIMORE CITY OR COUNTY OF DEATH									
MISSOURI		UNITED STATES				ANNE ARUNDEL									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		U. S. NAVY		DEFENSE									
13. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN CROFTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS MAUDE GLAZE							
14. FATHER'S NAME JAMES F. JOBE						15. MOTHER'S MAIDEN NAME MAUDE GLAZE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
YES		1953-PRESENT		495-26-2495		ELLEN K. JOBE, 1445 CROFTON PARKWAY,									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MRI - Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?											
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE <i>James E. Whelan, M.D.</i>		TITLE (SPECIFY) M.D.		Deputy MEDICAL EXAMINER		DATE SIGNED 2-17-85									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 910 Primrose Rd. Annapolis, 21403													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Feb. 22, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery		23d. LOCATION CITY OR TOWN Arlington, Virginia		COUNTY		STATE					
Burial															
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND		23e. DATE REC'D. BY REGISTRAR FEB 25 1985		23f. REGISTERED SIGNATURE											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "or item 22" or item 23, any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5 03416
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
<u>Ethel John Ethelwinet Johns</u>						<u>2- 15-85</u>					<u>3 PM</u>	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		# UNDER 24 HRS
<u>Female</u>		<u>white</u>		MONTH	DAY	YEAR	<u>88</u>			MONTHS	DAYS	HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.			9. BALTIMORE CITY OR COUNTY OF DEATH					
<u>Howard Co. Md.</u>		<u>U.S.</u>		<u>MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></u>			<u>Anne Arundel</u>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
<u>Crofton MD</u>		<u>Crofton Convalescent Center</u>		<u>Nurse</u>			<u>Home</u>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
<u>MD</u>		<u>A/A</u>		<u>Annapolis</u>			<u>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>			<u>5 Revell St 21401</u>		
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
<u>George</u>		<u>Howard</u>		<u>Susan</u>			<u>218-36-8298</u>			<u>Thelma J. Hartman</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>218-36-8298</u>		16c. ADDRESS <u>5 Revell St ANNAPOLIS MD</u>			17. INFORMANT ADDRESS			<u>21401</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					<u>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			<u>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
22a. I certify that (1) (this hospital) attended the deceased from <u>10/19/80</u> to <u>1-15-85</u> , that (1) (we) lost saw the deceased alive on <u>1/15-85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
<u>Paul S. Rhodes M.D.</u>		<u>1667 Crofton Center Crt</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
<u>Cremation</u>		<u>Feb 18, 1985</u>		<u>Cedar Hill</u>			<u>Suitland</u>			<u>P.G. MD</u>		
24. FUNERAL DIRECTOR NAME		ADDRESS										
<u>Taylor F. Home - Annapolis, MD 21401</u>												
25c. ADDRESS		25d. FEB 21 1985										

1600' from shore

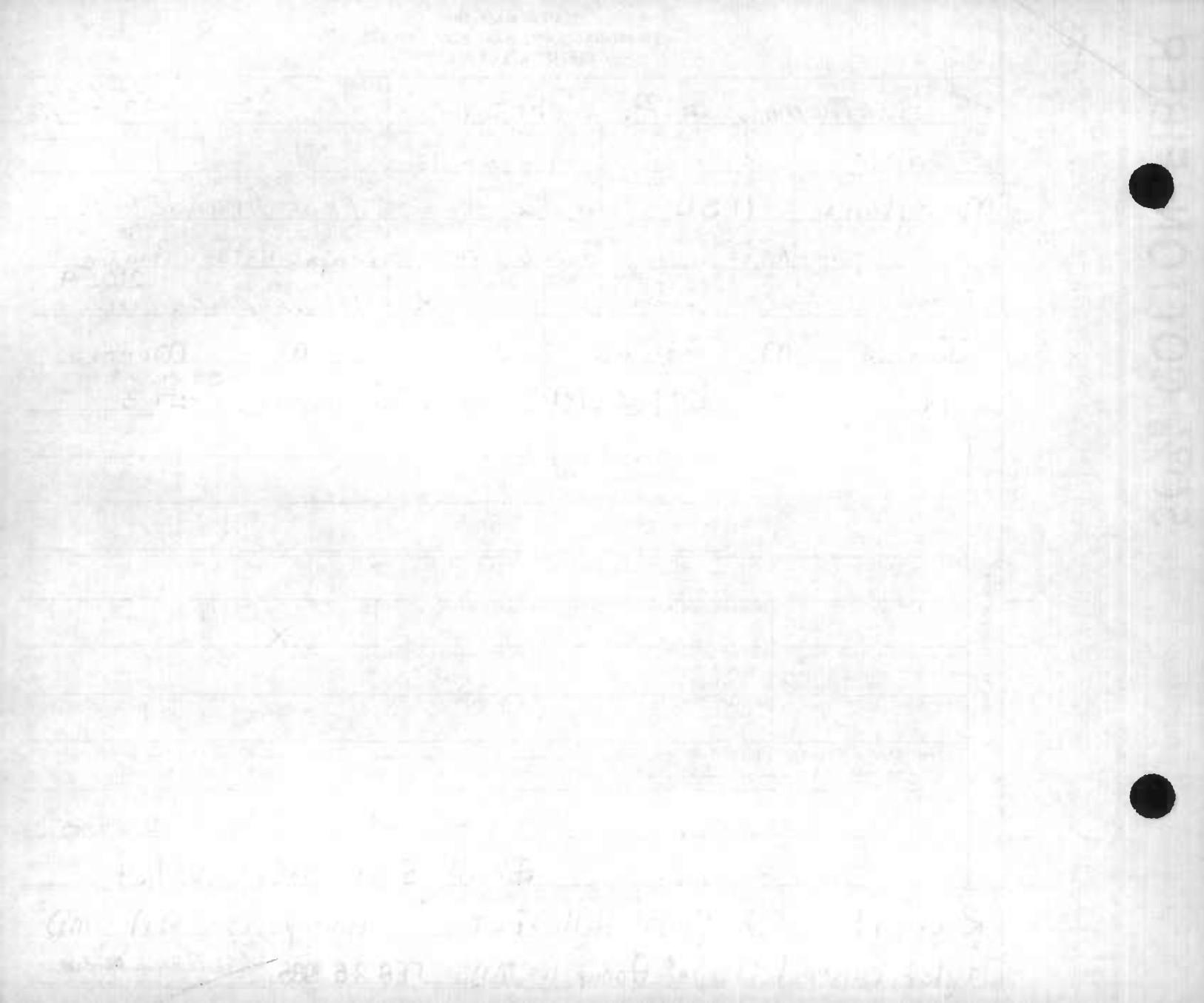
9.19 2005-2009

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be delivered to the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Forms 2 and 2A should be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical certifying officer should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 03417									
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR									
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2b. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
BerThamay B.A. Johnson												2-24-85		6		20		PM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				IF UNDER 24 HRS					
Female			White			MONTH 9 DAY 3 YEAR 13			71			MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			ANNE Arundel Co., MD.									
Maryland			USA																		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
ANNAPOLIS, MD.			ANNE Arundel General Hospital									Carpenter				Printing					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		ZIP CODE		21054					
Md. 21054			A. ACO.			Gambrills, MD						2121 HALLMARK DRIVE									
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			ADDRESS				Same as #13					
James			m.			Adams			Bertha			Morris									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			respiratory failure									
ND			579-03-8981			James T. Johnson-															
												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																(b) pneumonia					
																(c)					
DUE TO, OR AS A CONSEQUENCE OF																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																22c. DATE SIGNED					
																2-24-85					
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN			22e. MEDICAL DIRECTOR			STAFF PHYSICIAN									
Julie Buchanan			M.D.			<input type="checkbox"/>			<input checked="" type="checkbox"/>			<input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS																		
Julie Buchanan			Shady Side MD																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE							
Burial			Feb. 27, 1985			Hillcrest			Annapolis			AA		MD							
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Taylor Funeral Chapel - Annapolis, MD									FFB 26 1985			Julie Davidson Pendall									



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, file it in the funeral director's office. Please remove carbon copies. Pages 1 through 3 should be filed within 72 hours after death.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

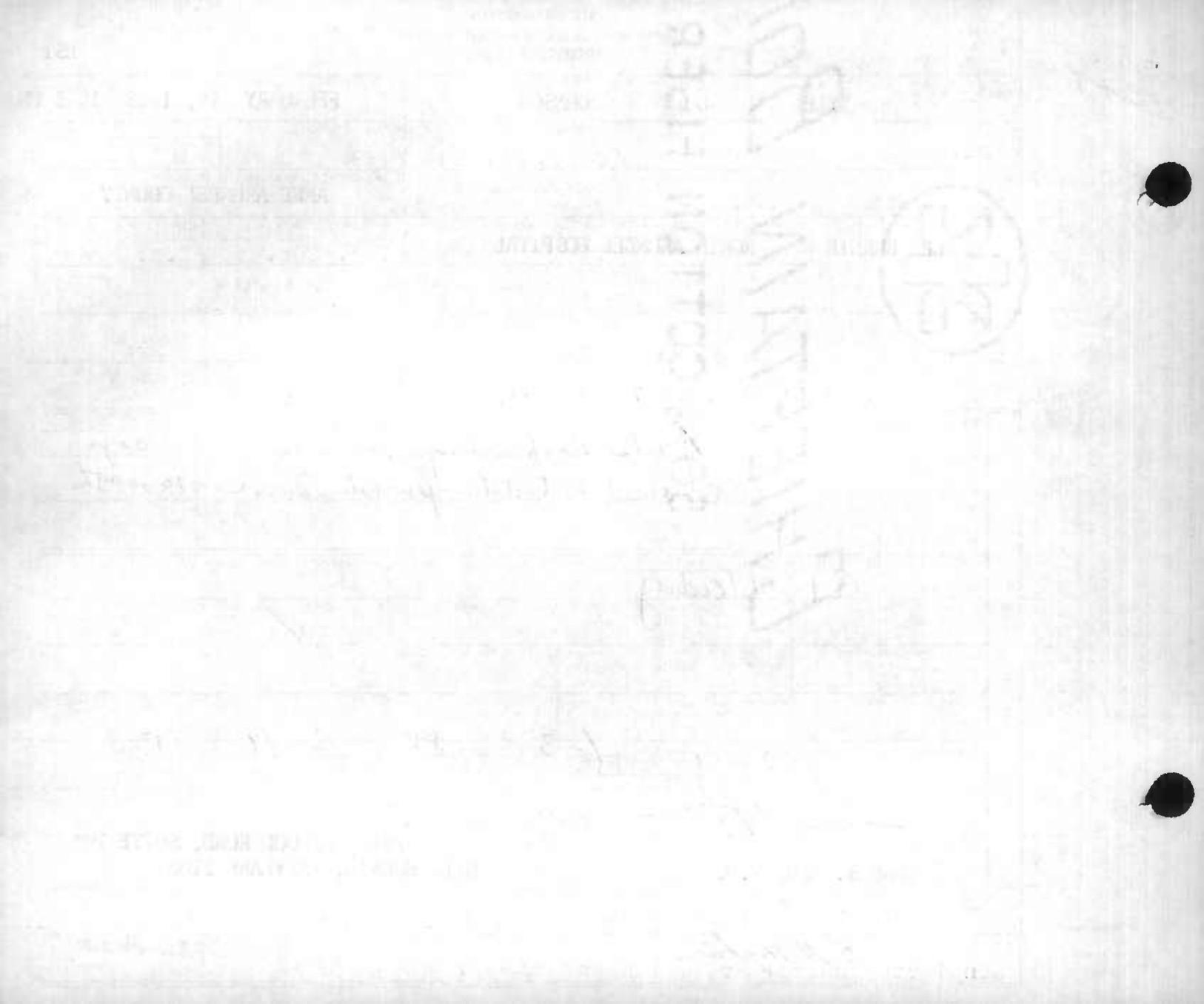
**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

E 8 5 0 3 4 1 8  
EST  
MS. B.2.1

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LYLE ORVILLE JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 19, 1985	2b. HOUR 1045 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 23, 1916	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Dakota	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 1st. Sgt.	12b. KIND OF BUSINESS OR INDUSTRY U.S. Army
13a. STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7220 Judy Road 21061
14. FATHER'S NAME FIRST MIDDLE LAST Fred Johnson, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olga Stai	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. W W II Korean	17. INFORMANT (Wife) Mrs. Waltraut E. Johnson	ADDRESS Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>advanced metastatic prostate Cancer</u> <u>10 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a G 1 Bleeding				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (FATHER, MOTHER, MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) 21d. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
22c. I certify that (I) (this hospital) attended the deceased from <u>2-19-85</u> to <u>2-19-85</u> that (I) (we) last saw the deceased alive on <u>2-19-85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22d. SIGNATURE <u>J. L. Hsu</u>		DEGREE MD.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED
22f. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M.D.		22g. ADDRESS 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb 23, 1985	23c. NAME OF CEMETERY OR CREMATORIAL Crest Lawn Cem.	23d. LOCATION CITY OR TOWN Marriottsville	23e. COUNTY Howard Md.
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, Md.	25a. DATE REC'D. BY REGISTRAR FEB 22 1985		25b. REGISTRATION SIGNAL John Patterson Pendell	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed [filled in by the funeral director, page 3] should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, no medical examination is required.

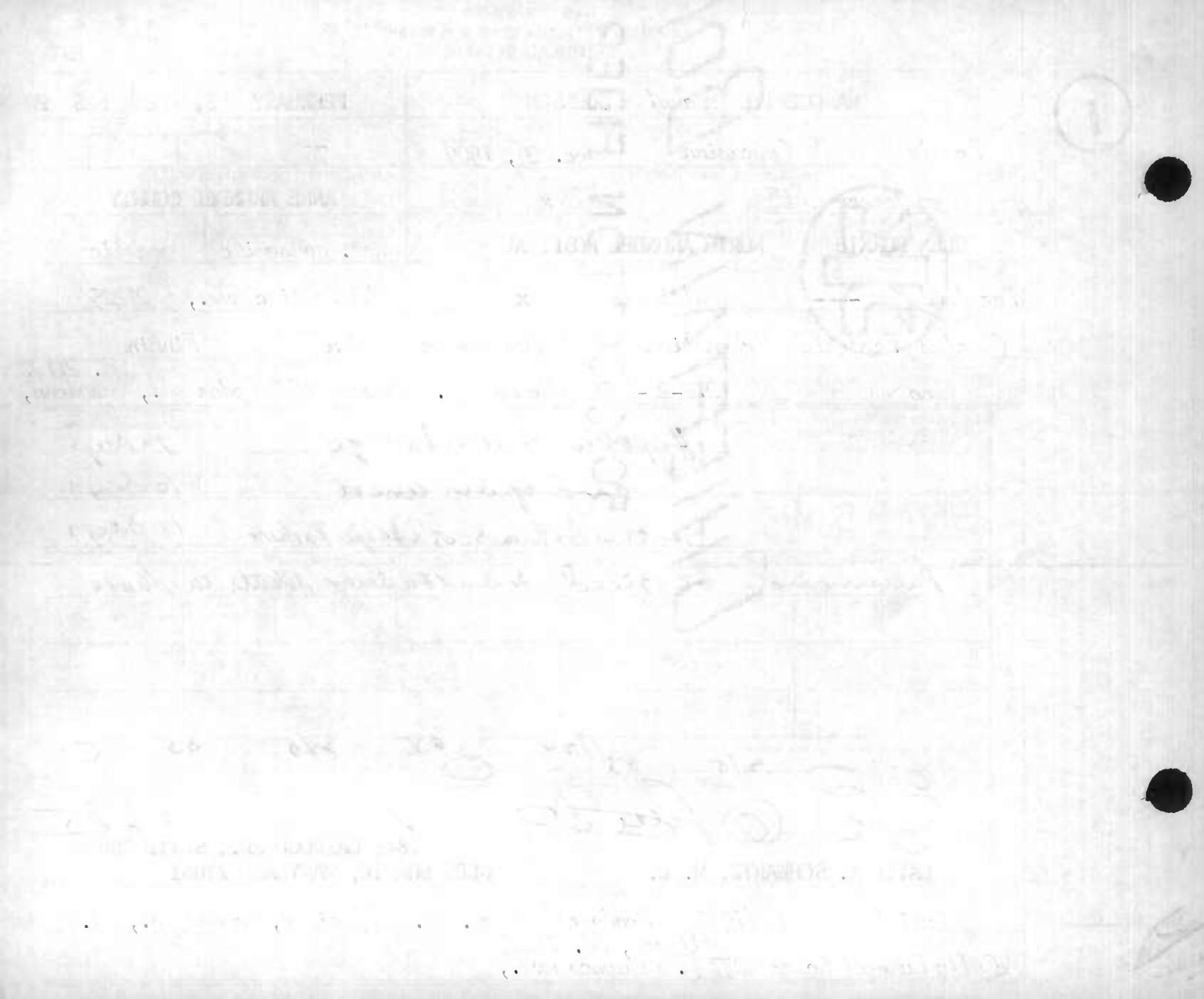
## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

EST

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			MARGUERITE M abel JOHNSON			FEBRUARY 5, 1985			625 PM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Female			Caucasian			Dec. 26, 1909			75 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			IF UNDER 1 YEAR MONTHS DAYS		
New Jersey			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			IF UNDER 24 HRS MONTHS HOURS MIN.		
11. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			9. BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
GLEN BURNIE			NORTH ARUNDEL HOSPITAL			ANNE ARUNDEL COUNTY MD.			Ret. Housewife		
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland			Baltimore						843 Pontiac Ave., 21225		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST		
Charles Frederick Rubenstier						Margarette Ann			Finnin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no			212-26-2379			Kenneth H. Johnson			Md. 21122 1888 Cedar Rd., Pasadena,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
						(b) <u>Hypoxic Brain Damage</u>			10 days		
						(c) <u>cardiopulm arrest</u>			10 days		
						(d) <u>status Asthmatics + Perip Failure</u>			11 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>1/24</u> 19 <u>85</u> to <u>2/5</u> 19 <u>85</u> , that (I) (we) last saw the deceased at <u>2/5</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			DAVID A. SCHWARTZ, M. D.			22e. ADDRESS			22f. DATE SIGNED		
						7845 OAKWOOD RD., SUITE 200			2/6/85		
						GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
Burial			2/8/1985			Meadowridge Mem. Pk.			Elkridge, Howard Co., Md.		
24. FUNERAL DIRECTOR			NAME McCULLY Funeral Homes			ADDRESS 237 E. Patapsco Ave.,			25a. DATE REC'D. BY REGISTRAR		
									25b. REGISTRAR'S SIGNATURE		
									FEB 7 1985 d		



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.

**TO FUNERAL DIRECTOR:** PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PR-3, RETAIN PAGE 4 AND 5 FOR YOUR USES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03420

REG. NO.

1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	XX	MONTH	DAY	YEAR	2b. HOUR	
Raymond Joseph Keating						FEB. 2	1985				M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d HOUR	
MALE	WHITE	OCT. 18, 1955	29 yrs.	MONTHS	DAYS	HOURS	MIN	FEB. 2	1985		12:25 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			Anne Arundel County, MD.	
NEW JERSEY		U.S.A.					DIVORCED <input type="checkbox"/>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Glen Burnie		North Arundel Hospital			FREIGHT HANDLER			CARGO				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			21061	
MD		A.A.		GLEN BURNIE				314 HIGHLAND DRIVE APT. 204				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
JAMES		E.		KEATING		ANNA		MARIE		KOPP		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT (WIFE)		ADDRESS						
NO		N/A		214.66.2419		MRS. SHELIA L. KEATING SAME AS 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  8150 IMMEDIATE CAUSE (a) Blunt Trauma to Chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 11:00PM 2-2 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) driver in auto/fixed object impact							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway			21f. LOCATION STREET Hospital Dr. at entrance to Southgate Mall,			CITY OR TOWN COUNTY STATE Glen Burnie, Anne Arundel Co., MD				
22a. I certify that I took charge of the remains described above, held on death resulted from Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i>		TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 2-3-85				
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN GLEN BURNIE		COUNTY A.A.		STATE MD		
BURIAL		FEB. 7, 1985		GLEN HAVEN MEM. PARK								
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
SINGLETON		FUNERAL HOME GLEN BURNIE, MD 21061		FEB 5 1985		<i>Julee Davidson-Rendell</i>						
DHMH - 17 (VR A15 ME (5))												

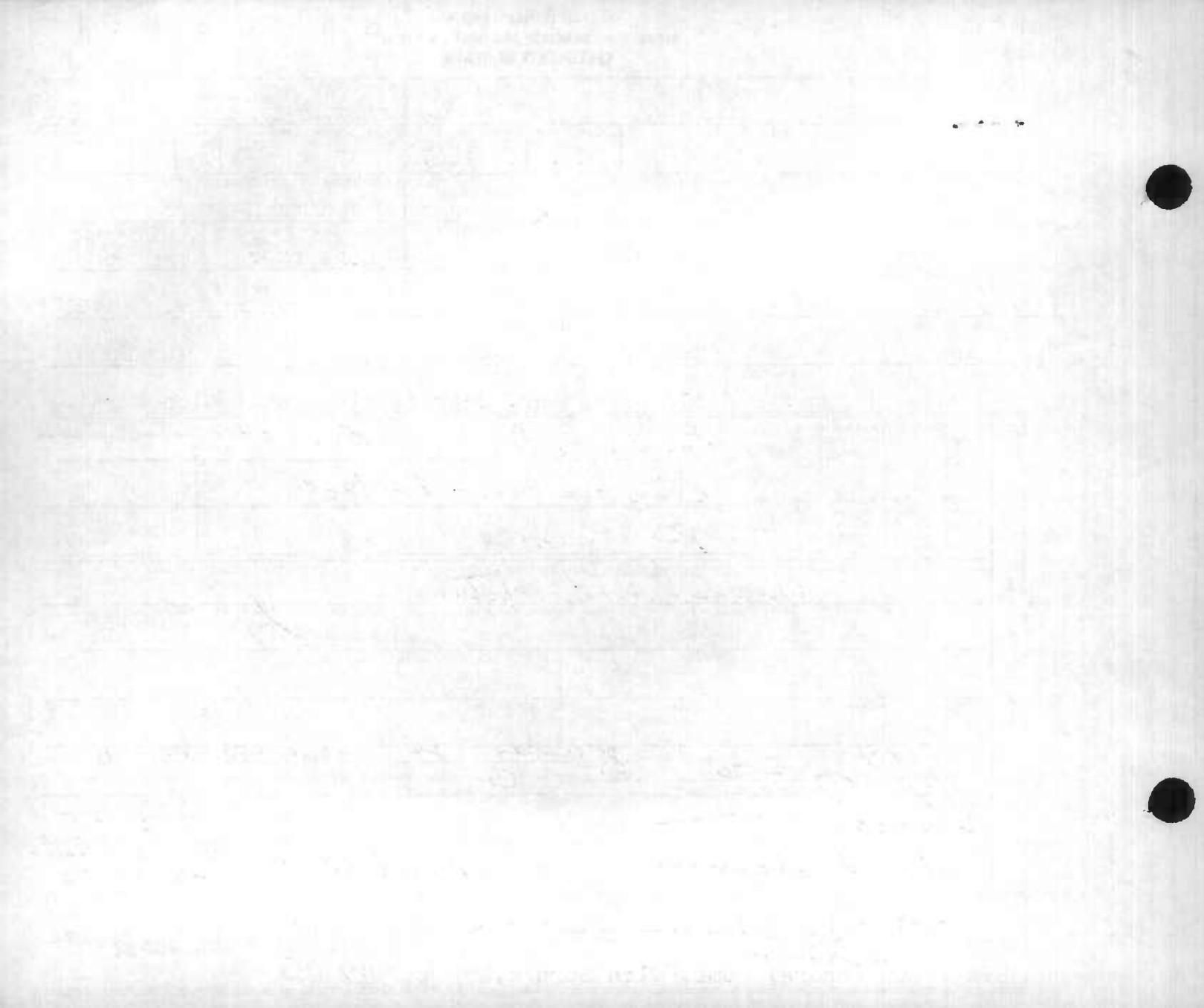


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3  
should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 4 and 5 should be filed within 72 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. EST	
1 - FOR STATE REGISTRAR						
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST	2a. DATE OF DEATH	MONTH DAY YEAR	2b. HOUR P M
ANNIE ELIZABETH KING			FEBRUARY 20, 1985		3:00 P M	
3. SEX		4. RACE	5. DATE OF BIRTH			
female		white	Oct. 13, 1887			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH	
MD		USA	NEVER MARRIED X DIVORCED		ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL			12b. KIND OF BUSINESS OR INDUSTRY Homemaker own home	
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 475 Patuxant Rd. 21133		
MD	AA	Odenton				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachael (UNKNOWN)			
Asa			Tucker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
NO XXXXXXXX		217/50/9928		Mr. Charles King (son)		Glen Burnie, MD
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart Failure</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Urinary tract infection</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <i>December 19, 84</i> to <i>February 20, 1985</i> , that (2) we last saw the deceased alive on <i>2-20-85</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Edward Sherman</i> DEGREE						
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edward Sherman</i> 22e. ADDRESS <i>8726 Liberty Plaza Mall, Hunt Valley, MD 21133</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 23c. NAME OF CEMETERY OR CREMATORIAL Nichols Bethel 23d. LOCATION CITY OR TOWN Odenton COUNTY AA STATE MD						
24. FUNERAL DIRECTOR NAME <i>Johns</i> ADDRESS						
Singleton Funeral Home, Glen Burnie, MD 25a. DATE REC'D. BY REGISTRAR <i>Johns</i> 25b. REGISTRATION NUMBER FEB 22 1985						



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 03422

1 - STATE  
REGISTRAR

REG. NO.

EST

1 DECEASED NAME <b>ETTA MAE KIRBY</b>				2a DATE OF DEATH <b>FEBRUARY 15, 1985</b>	MONTH <b>FEB</b>	DAY <b>15</b>	YEAR <b>1985</b>	2b HOUR <b>11:20 AM</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>CAU.</b>		5. DATE OF BIRTH <b>JULY 18, 1937</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>47</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>	
7a BIRTHPLACE <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10 CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a USUAL OCCUPATION <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GLEN BURNIE</b>	
13a STATE <b>MD.</b>		13b COUNTY <b>A.A.</b>		13c CITY OR TOWN <b>GLEN BURNIE</b>		13d INSIDE CITY LIMITS? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		13e STREET ADDRESS / ZIP CODE <b>1618 PLEASANTVILLE DR. 21061</b>	
14 FATHER'S NAME FIRST <b>FREDERICK</b>		MIDDLE <b>CAVEY</b>		LAST		15. MOTHER'S MAIDEN NAME <b>VIRGIE</b>		LAST <b>MOLESWORTH</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>216-34-9048</b>		16c PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Brechogenic carcinoma with extensive brain metastasis</b>		17 INFORMANT <b>DONALD E. KIRBY</b>		ADDRESS <b>GLEN BURNIE 1618 PLEASANTVILLE DR. 21060</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Brechogenic carcinoma with extensive brain metastasis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Cerebrovascular accident secondary from the brain metastasis</b>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY	
22a I certify that (I) (this hospital) attended the deceased from <b>2/9</b> , 19 <b>85</b> , to <b>2/15</b> , 19 <b>85</b> , that (I) (was) lost saw the deceased alive on <b>2/15</b> , 19 <b>85</b> , and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.									
22b. SIGNATURE <b>HD</b>		DEGREE		22c DATE SIGNED <b>2/15/85</b>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>DO-HSIU Hung</b>		22e ADDRESS <b>3450 Ft. Meade Rd. 307 Laurel, Md. 20707</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>02-18-85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>LAKEVIEW CEMETERY</b>		23d. LOCATION <b>CARROLL CO., MARYLAND</b>			
24 FUNERAL DIRECTOR <b>HOWARD HUBBARD FUNERAL HOME, INC.</b>		ADDRESS <b>4107 WILKENS AVE. BALTO., MD.</b>		25a DATE REC'D. BY REGISTRAR <b>FEB 20 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Howard Hubbard</b>			

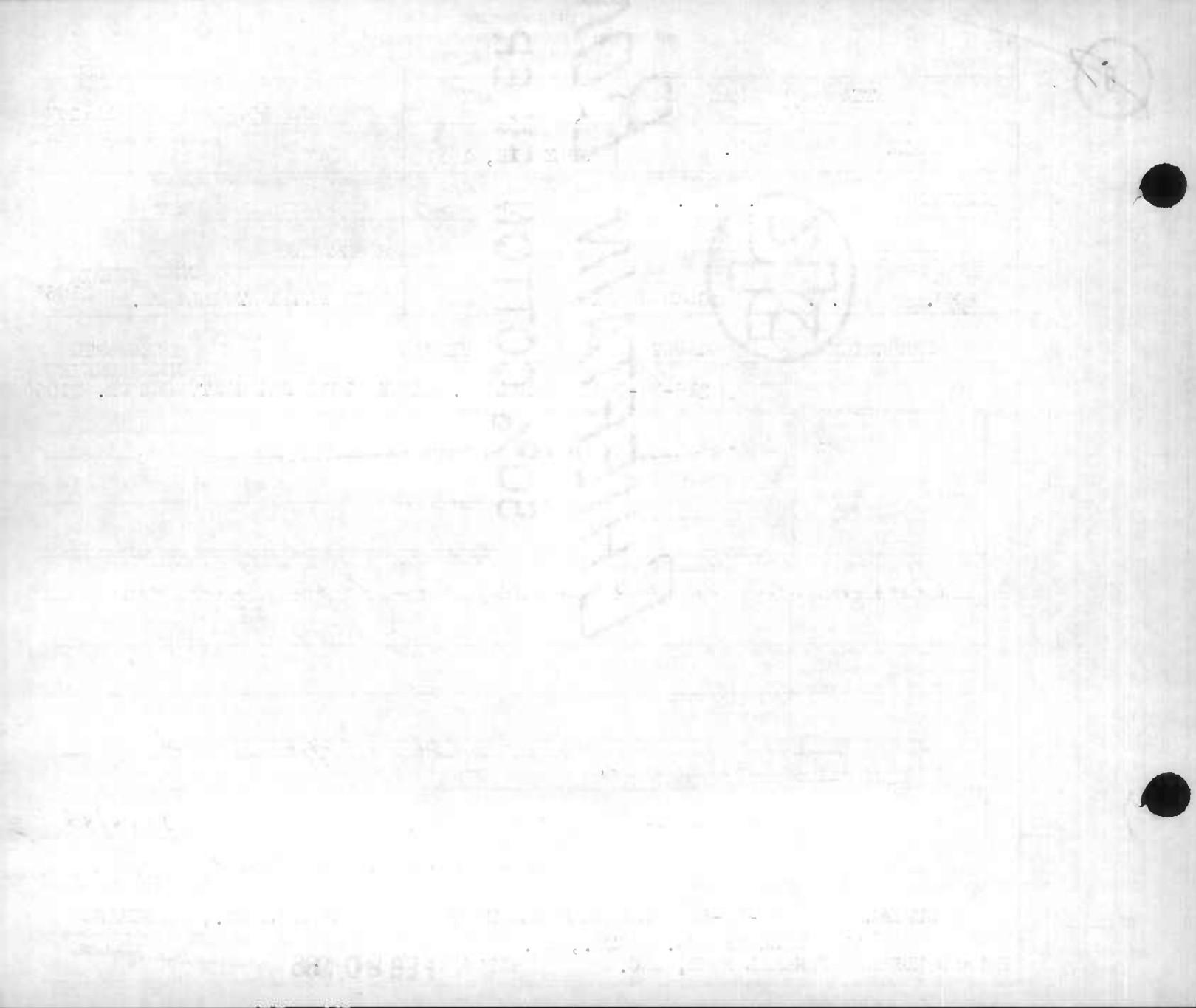
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, by the hospital or attending physician.

REMAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 03423			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR A.M. P.M.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			February 28, 1985			3:50			
Katherine			M.			Kissner									
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female			Caucasian			May 4, 1902			82 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Anne Arundel County MD.			
Maryland			USA												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Crofton			Crofton Convalescent Center									Telephone Oper. US Government			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Florida						Clearwater						2305 Chaucer St. 99999			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Clarence Tracey			Edith R. Myers												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. -----			17. INFORMANT			6008 Gordon Drive Sunderland, MD 20689			ADDRESS			
			579-60-5361			Kerry Preacher									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>History of Heart Attack: X 4; History of Breast Cancer</b>															
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Dec. 22, 1984, to Feb. 28, 1985, that (I) (we) last saw the deceased alive on Feb. 22, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													22c. DATE SIGNED Feb. 28, 1985		
22b. SIGNATURE Frank R. Jackson			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS 3 Village Green Crofton, Maryland 21114						
22d. PHYSICIAN'S NAME* (TYPE OR PRINT) Dr. Frank R. Jackson, M. D.															
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Cremation			23b. DATE Feb. 28 1985			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory Alexandria, Fairfax, Virginia			23d. LOCATION CITY OR TOWN COUNTY STATE						
24. FUNERAL DIRECTOR NAME Beall Funeral Home			16000 Annapolis Rd.			Bowie, MD 20715			25a. DATE REC'D. BY REGISTRAR MAR 1 1985			25b. REGISTRAR'S SIGNATURE Lisa Davidson Mandell			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1. FOR STATE REGISTRAR			Elizabeth G. Koffroth														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
			ELIZABETH G. KOFFROTH			2/28/85						~5:30 PM					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
Female			White			MONTH DAY YEAR			78			MONTHS	DAYS	IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Pennsylvania			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Anne Arundel Co.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Pasadena			Home - 7696 Colonial Bch Rd.									Homemaker			21122		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
Md.			A.A. Co.		Pasadena					7696 Colonial Bch Rd.							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST						
			Lemick		Rambo				Gertrude	L.	Winters						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
NO			156 18 6100			Shirley Miller same as 13 e											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <u>Candidiasis, rectal</u>												immediate					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic breast disease</u>												~1 1/2 years					
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
			—			—											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			—								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE —			—								
22a. I certify that (I) (this hospital) attended the deceased from Jan. 12, 1984, to Feb. 28, 1985, that (I) (we) last saw the deceased alive on Dec. 12, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 3/1/85					
22b. SIGNATURE <u>Christine A. Marino, MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS 1667- Fort Smallwood Rd. Pasadena, Md								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Christine A. Marino, MD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3/1/85			23c. NAME OF CEMETERY OR CREMATORIAL Westview Mem Pk			23d. LOCATION CITY OR TOWN Baltimore, Maryland			COUNTY STATE					
24. FUNERAL DIRECTOR NAME George J. Gonce ADDRESS 4001 Ritchie Hwy.			21225						25a. DATE REC'D. BY REGISTRAR MAR 4 1985			25b. REGISTRAR'S SIGNATURE <u>Laurelton Pendleton</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be forwarded to the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be forwarded to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.  
3503425

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<i>Michael Joseph Kupfer Sr.</i>						<i>2 6 85</i>				<i>4:55 A.M.</i>			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		# UNDER 1 HOUR HOURS MIN.			
<i>Male</i>		<i>White</i>		<i>Sept. 29, 1917</i>		<i>67</i>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
<i>West Virginia</i>		<i>U.S.A.</i>				<i>ANNE Arundel</i>							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
<i>Annapolis</i>		<i>ANNE Arundel Gen.</i>		<i>Shop Manager</i>		<i>Automotive</i>							
13a. STATE <i>Maryland</i>						13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>701 Glenwood St. Apt. 509 21403</i>	
14. FATHER'S NAME FIRST		MIDDLE <i>V.</i>		LAST <i>Kupfer</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Helen</i>		MIDDLE		LAST <i>O'Neill</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>233-03-0063</i>		17. INFORMANT		1023 ADDRESS <i>Old Bayridge Road</i>					
<i>Yes</i>		<i>WW II</i>				<i>Mark C. Kupfer Annapolis, Maryland 21403</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septicemia with E. coli</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Morbid obesity / Anasarca</i>													
19a. DATE OF OPERATION <i>N/A</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>4 Feb 85</i> to <i>6 Feb 85</i> that (I) (we) last saw the deceased alive on <i>5 Feb 85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Charles W. Kinzer</i>						DEGREE							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles W Kinzer MD</i>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22e. ADDRESS <i>Annapolis, Maryland</i>						22f. DATE SIGNED <i>6 Feb 85</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>02/07/1985</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Green Mount Crematory</i>		23d. LOCATION CITY OR TOWN <i>Baltimore City, Maryland</i>							
24. FUNERAL DIRECTOR NAME <i>Walter Brooks Bradley, Inc, Balto., MD 21222</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>FEB 8 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Jean Davidson Pendell</i>							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 03420	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR			2b. HOUR				
Eric			M.	Leonhard		ESTI- DEATH MATED	<input type="checkbox"/>	2-20 19 85	M				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			2d. HOUR				
Male	White	5 2 1943	41 yrs.			2-20 19 85	9:51 a.m.		M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Conn.		U.S.A.						Anne Arundel County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Annapolis		Anne Arundel General Hospital			Cabinet Maker								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
MD		Anne Arundel		Annapolis		YES <input checked="" type="checkbox"/>		1739 Daevan Trail 21401					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			ADDRESS						
Julius			Leonhard	Gentude			Tessier						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No					Deborah Leonhard # 13e								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (e.g.)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Dennis F. Smyth Assistant			MEDICAL EXAMINER			DATE SIGNED 2-21-85					
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth M.D.			ADDRESS 111 Penn St., Balto., Md. 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Cremation 2/22/85		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cem.			23d. LOCATION CITY OR TOWN Suitland			COUNTY PG STATE MD			
24. FUNERAL DIRECTOR NAME		ADDRESS Taylor Funeral Chaple 1476 Gloucester St. Baltimore			25a. DATE REC'D. BY REGISTRAR FEB 26 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandell					
DHMH - 17 (VR A15 ME (5))													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85 03 21	
												REG. NO.	
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			<i>MABEL</i>			<i>LEWIS</i>			<i>2-7-85</i>			<i>2:30 AM</i>	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			26. HOUR IF UNDER 24 HRS HOURS MIN.	
<i>FEMALE</i>			<i>WHITE</i>			<i>12 07 1905</i>			<i>79</i> <i>YRS.</i>			<i>2:30 AM</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH	
<i>USA - Md.</i>			<i>USA</i>						<i>ANNE ARUNDEL Co</i>			<i>Annapolis</i>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			12b. KIND OF BUSINESS OR INDUSTRY				
<i>ANNE ARUNDEL GENERAL Hosp.</i>			<i>HOUSEWIFE</i>			<i>YES</i>			<i>—</i>				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13e. STREET ADDRESS			14. FATHER'S NAME FIRST MIDDLE LAST	
<i>Md.</i>			<i>A.A.</i>			<i>FRIENDSHIP</i>			<i>99 FRIENDSHIP Rd</i>			<i>William Pitcher</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS	
<i>NO</i>			<i>212-74-7279</i>			<i>GEORGE R. LEWIS</i>						<i>99 FRIENDSHIP Rd</i>	
												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) <i>Fever</i>			(c) <i>Alimentary Pneumonia</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I/we) last saw the deceased alive _____, 19_____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I also certify that I did not view the body after death.													
22b. SIGNATURE <i>You</i>			22c. DEGREE <i>B.S. 1978</i>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>5/26/85</i>				
22f. PHYSICIAN'S NAME (TYPE OR PRINT)						22g. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>Feb 10, 1985</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>FRIENDSHIP CHURCH</i>			23d. LOCATION CITY OR TOWN <i>FRIENDSHIP AA</i> COUNTY <i>MD.</i>				
24. FUNERAL DIRECTOR NAME <i>Rausch Mt. Harmony Lane Owings MD</i>			25a. ADDRESS <i>FEb 13 1985</i>			25b. DATE REC'D. BY REGISTRAR <i>Davidson-Randall</i>			25c. REGISTRAR'S SIGNATURE				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner will be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8503428	EST						
1 - FOR STATE REGISTRAR			REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
ROBERT			LEROY	LEWIS		FEBRUARY			5	1985	314 AM								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male			White			November 8, 1923			61			MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Pennsylvania			USA						ANNE ARUNDEL COUNTY										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
GLEN BURNIE			NORTH ARUNDEL HOSPITAL									Mech. - Retired			Am-Tec				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21076						
Md.			AA		Hanover					Chesapeake Mobile Court, Lot 82									
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST								
Ernest			R.	Lewis		Mary			B.	Weir									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS										
Yes			WW 2			199-12- 7719			Betty Lewis, Wife, same as 13										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carrie staudtell</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																			
{ (b) <u>acute myocardial infarction</u>																			
{ DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>advanced emphysema</u>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) this hospital attended the deceased from <u>3/4/85</u> , to <u>1985</u> , to <u>1985</u> , that (I) we last saw the deceased alive on <u>3/4/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED							
22b. SIGNATURE <u>James S. Benjamin MD</u>												DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>James S. Benjamin</u>			22e. ADDRESS 7300 RITCHIE HIGHWAY GLEN BURNIE, MARYLAND 21061																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8 Feb. 85			23c. NAME OF CEMETERY OR CREMATORIAL Crownsville Veterans			23d. LOCATION CITY OR TOWN Crownsville AA			COUNTY		STATE Md.					
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Md.												25a. DATE REC'D. BY REGISTRAR FEB 7 1985		25b. REGISTRAR'S SIGNATURE <u>James S. Kirkley</u>					

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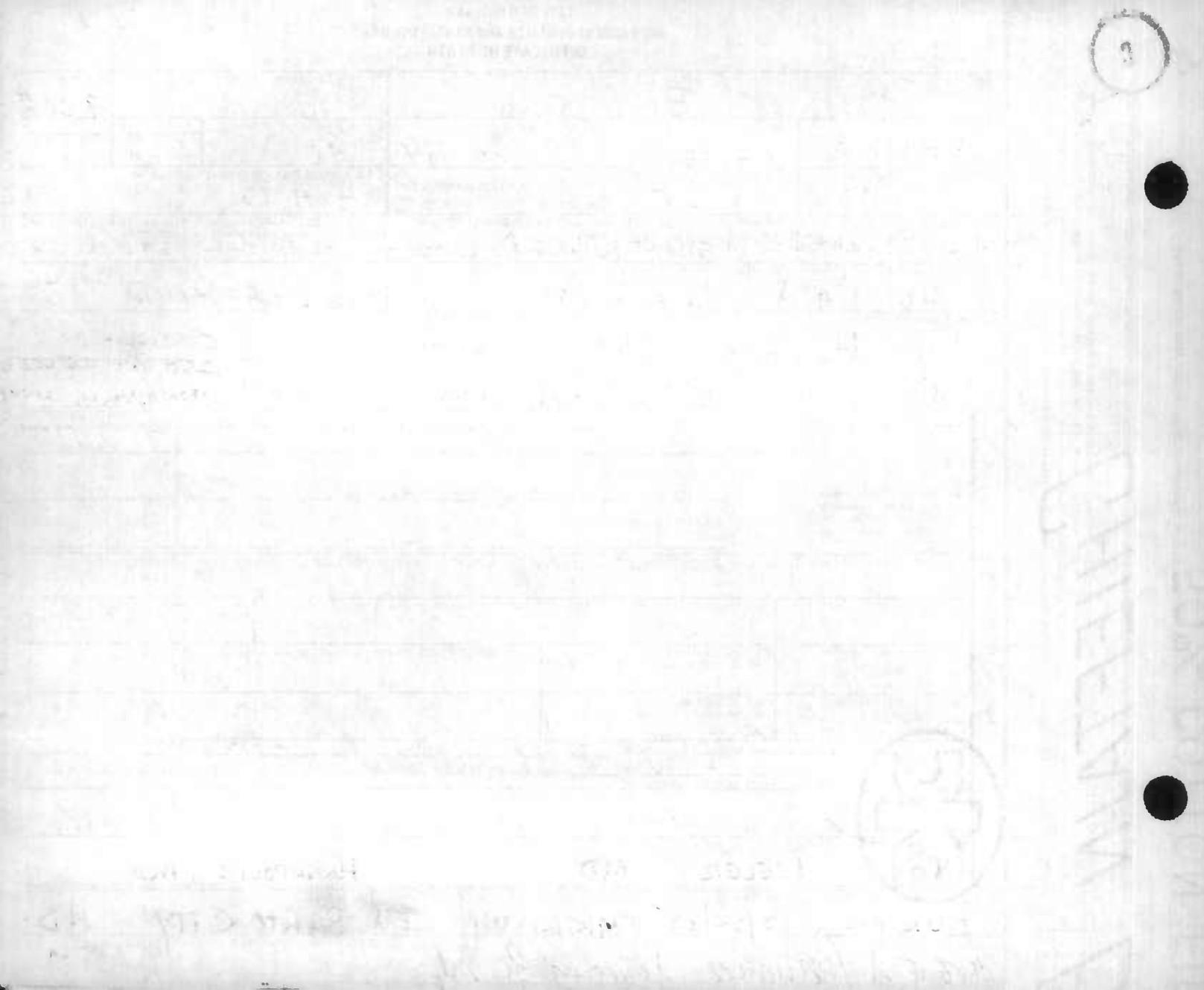
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 and 2 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 03429						
										REG. NO.						
1 - STATE REGISTRAR			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			Margaret E. Lindeman			2/20/85						9:00 AM				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
FEMALE			WHITE			12 - 20 - 94			96			YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
A.A. EDGEWATER			USA						A.A.C.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
MD A.A.			SEVERNA PK			CLERICAL			STEEL CO			21146				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
MD			A.A.			SEVERNA PK						576 BTA BLVD				
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
Wm. H. LINDEMAN						ANNIE			213093279			ANNE L. NEU-ANNAPOLIS			250 PROVIDENCE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
No			213093279			minutes										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Ankle pulmonary edema													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			Due to, or as a consequence of (b) arteriosclerotic C-V disease													
			Due to, or as a consequence of (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 2/20/85 to 2/20/85, that (I) (we) last saw the deceased alive on 2/20/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			2/20/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			MD			ADDRESS			ANNAPOULIS, MD							
23a. BURIAL, CREMATION, REMOVAL (SELECT ONE)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		MD.		
BURIAL			2/25/85			OAKLAWN CEM.			BALTIMORE CITY							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Robert J. Baunace			Severna Pk., MD			FEB 26 1985			Davidson							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return to hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 3503430			
1. FOR STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR 2-22-85									2b HOUR 4 <sup>40</sup> AM			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
LILLIAN MAE LINDEMURE						MARCH 24 1898			86 YRS.			MONTHS DAYS		HOURS MIN.	
3. SEX FEMALE			4. RACE WHITE			7b. CITIZEN OF WHAT COUNTRY? UNITED STATES			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. MD.			
10. CITY OR TOWN OF DEATH EDGEWATER			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PLEASANT LIVING Conv Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home						
13a. STATE MARYLAND			13b. COUNTY ANNE ARUNDEL			13c. CITY OR TOWN SEVERNAPARK			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 144 WASHINGTON RD. 21146			
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE E. BANKS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET A. (UNKNOWN)			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. — 213-28-3521			17. INFORMANT DOROTHY MERKEL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ PNEUMONIA						DUE TO, OR AS A CONSEQUENCE OF (b) CHF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						DUE TO, OR AS A CONSEQUENCE OF (c) _____						YEARS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED <small>AT HOME AT WORK NOT WHERE AT WORK</small>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 7-29-82, 19 82, to 2-22-85, 19 85, that (I) (we) last saw the deceased alive on 2-13-85, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE John Lowe M.D.			22c. DEGREE			22d. DATE SIGNED 2/22/85									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) John S. Lowe M.D.			22f. ADDRESS WEST St. Annapolis MD												
23a. BURIAL, CREMATION, REMOVAL 15b. DATE BURIAL FEB. 25, 1985			23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY			23d. LOCATION CITY OR TOWN CITY STATE BALTIMORE MD									
24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME			ADDRESS 501 RITCHIE Hwy. SEVERNA PARK, MD 21146			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE John S. Lowe									



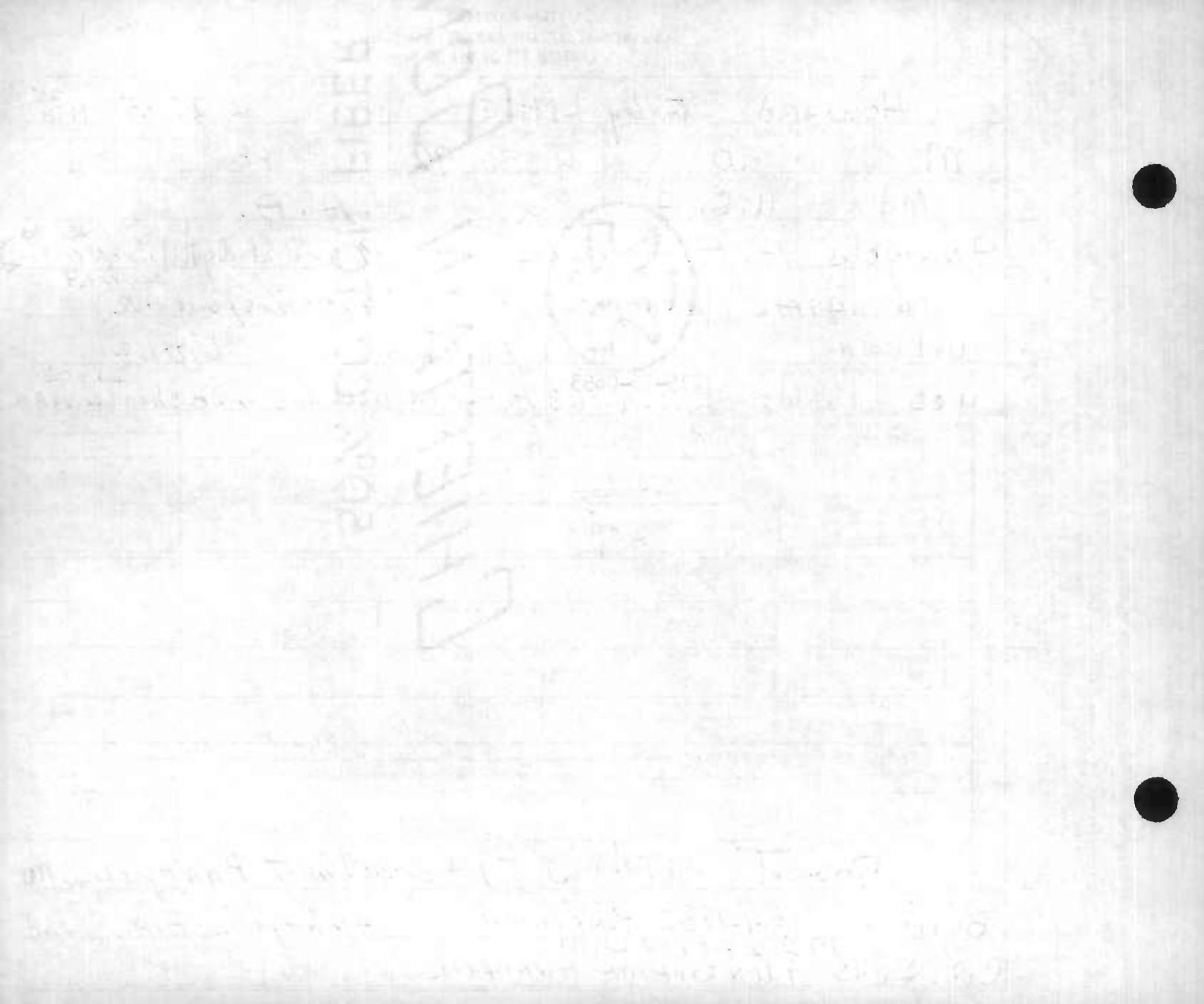
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										03431					
										REG. NO.					
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
			Howard Stanley Little						2 25 85				11 35 AM		
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
M			B			MONTH DAY YEAR			88 yrs			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Md			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			A.P.			Physical Ed Dept U.S. NAVY			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SURFACE FACILITY, ONE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
ANNAPOLIS			A.F. GENERAL			Physical Ed Dept U.S. NAVY			21403			21403			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Md			Anne Arundel			Annapolis			YES			420 Chesapeake Ave			
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			17. INFORMANT			
			Unknown			LUVENIA			NO			H. Florine Williams			
												ADDRESS			
												21403			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <del>Aspirin</del> CONC. NJ. FAILURE												
			(c) <del>Aspirin</del>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
Robert BERN MD			51 Franklin St Annapolis, Md												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
Burial			3-1-1985			Pine Lawn			Annapolis			B.B.	md		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
C.E. Hicks			1922 Forest Drive			SMART			1985			John J. L. ...			
FURNER Home ANNAPOLIS															



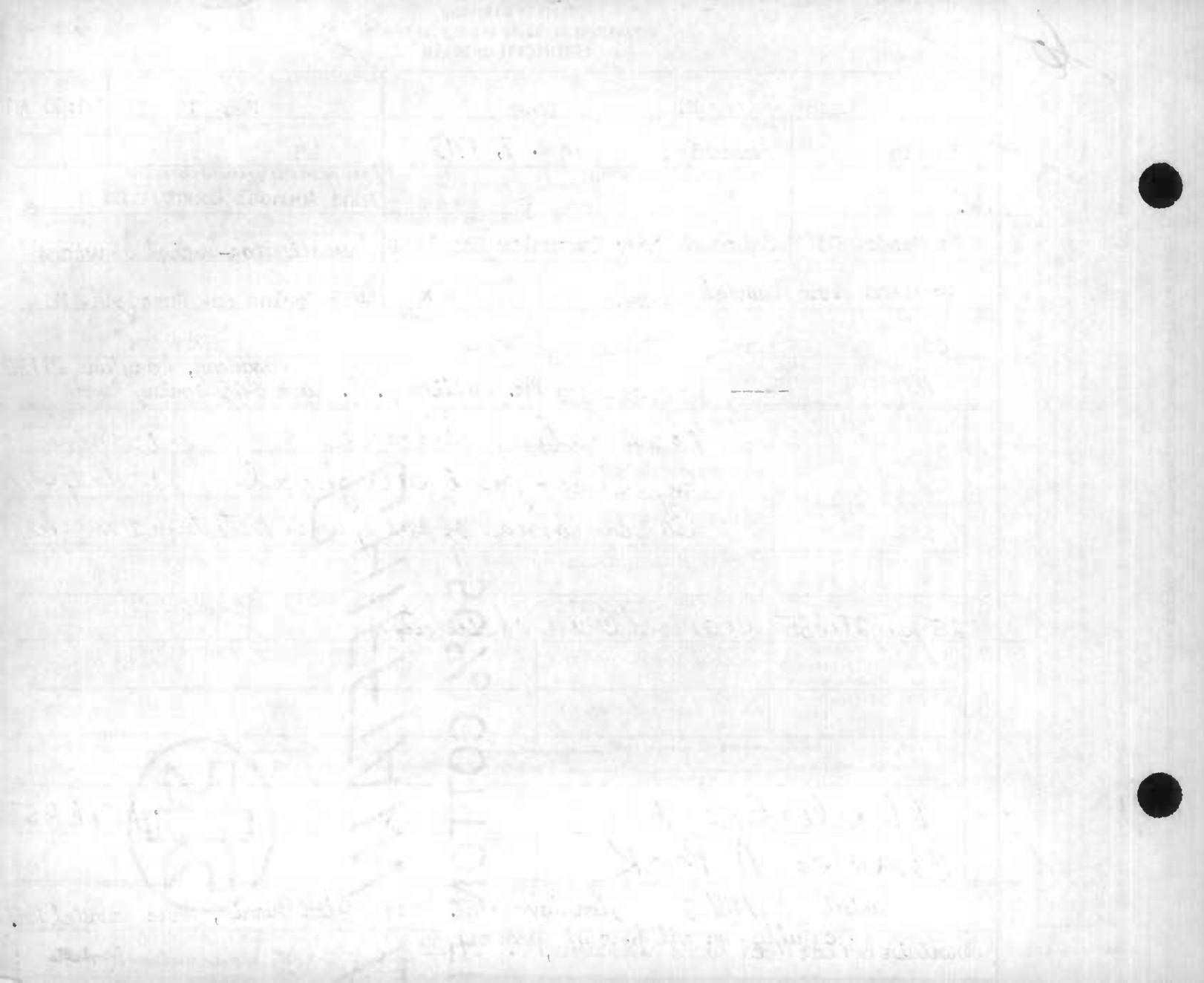
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be informed at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 85 03432		
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH Feb 14 85							MONTH DAY YEAR	2b. HOUR 10:00 AM	
1. DECEASED NAME (TYPE OR PRINT)			FIRST Leah	MIDDLE M.	LAST Lowe							
3. SEX Female			4 RACE Caucasian		5. DATE OF BIRTH Sept. 7, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. USA			7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, Md MD.					
10. CITY OR TOWN OF DEATH Ft Meade, Md			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Kimbrough Army Community Hospital		(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION Investigator-Social Services			12b. KIND OF BUSINESS OR INDUSTRY 21122	
13a. STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 8425 Spring Rd., Pasadena, Md		
14. FATHER'S NAME FIRST John			MIDDLE Edward	LAST Eidmen	15. MOTHER'S MAIDEN NAME FIRST Emma			MIDDLE	LAST Schwemm			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 231-16-0537		17. INFORMANT Mr. Hollice J. E. Lowe			Pasadena, Maryland 21122			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Respiratory failure								10 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis - post surgical								2 weeks.	
			DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of ovary with metastasis									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.												
19a. DATE OF OPERATION 25 Jan 2 Feb 85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Sigmoid Colon obstruction			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE Charles A Peck			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 14 Feb 85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles A Peck			22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/18/85		23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN Glen Burnie, Anne Arundel Md.			23e. COUNTY STATE		
24. FUNERAL DIRECTOR Mc Guity Funeral Home of Pasadena, Md. Mountain & 102 Neck Roads Pasadena, Md. 21122						25a. DATE REC'D. BY REGISTRAR FEB 19 1985			25b. REGISTRAR'S SIGNATURE John Davidson-Pandell			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												0 3 4 3 3					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	JOHN	MIDDLE	LAST	LUCAS	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR			
John						Lucas			<input checked="" type="checkbox"/>	2 25	1985						
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR				
M		CAN	7 25 27	57 yrs.			2 25 85			19	2200		M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH								
VIRGINIA			U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			77A								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Glen Burnie			North Arundel			MACHINIST			WESTINGHOUSE								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		21077						
Md			7 A.		Harman's				10 Harman's Rd.								
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		YAGER					
JAMES					LUCAS		MAMIE										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			SHENANDOAH, VA.					
NO			197-20-2045			DORIS BROWN P.O. BOX 126						22849					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																	
(b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Chronic Hepatic Failure																	
(c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?					
												<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY					
															STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		William P. Jones, M.D. Deputy MEDICAL EXAMINER										TITLE (SPECIFY)					
EXAMINER'S NAME (TYPE OR PRINT)		William P. Jones										ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE				
REMOVAL/BURIAL		03-01-85		REST HAVEN CEMETERY			SHENANDOAH			PAGE			VIRGINIA				
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 4107 WILKENS AVE.					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
BALTO., MARYLAND		21229					MAR 1 1985			John Pendleton							
BP _____																	
DHMH - 17 (VR A15 ME (5))																	
20M 4/82																	

5

March, 1919

B. B.



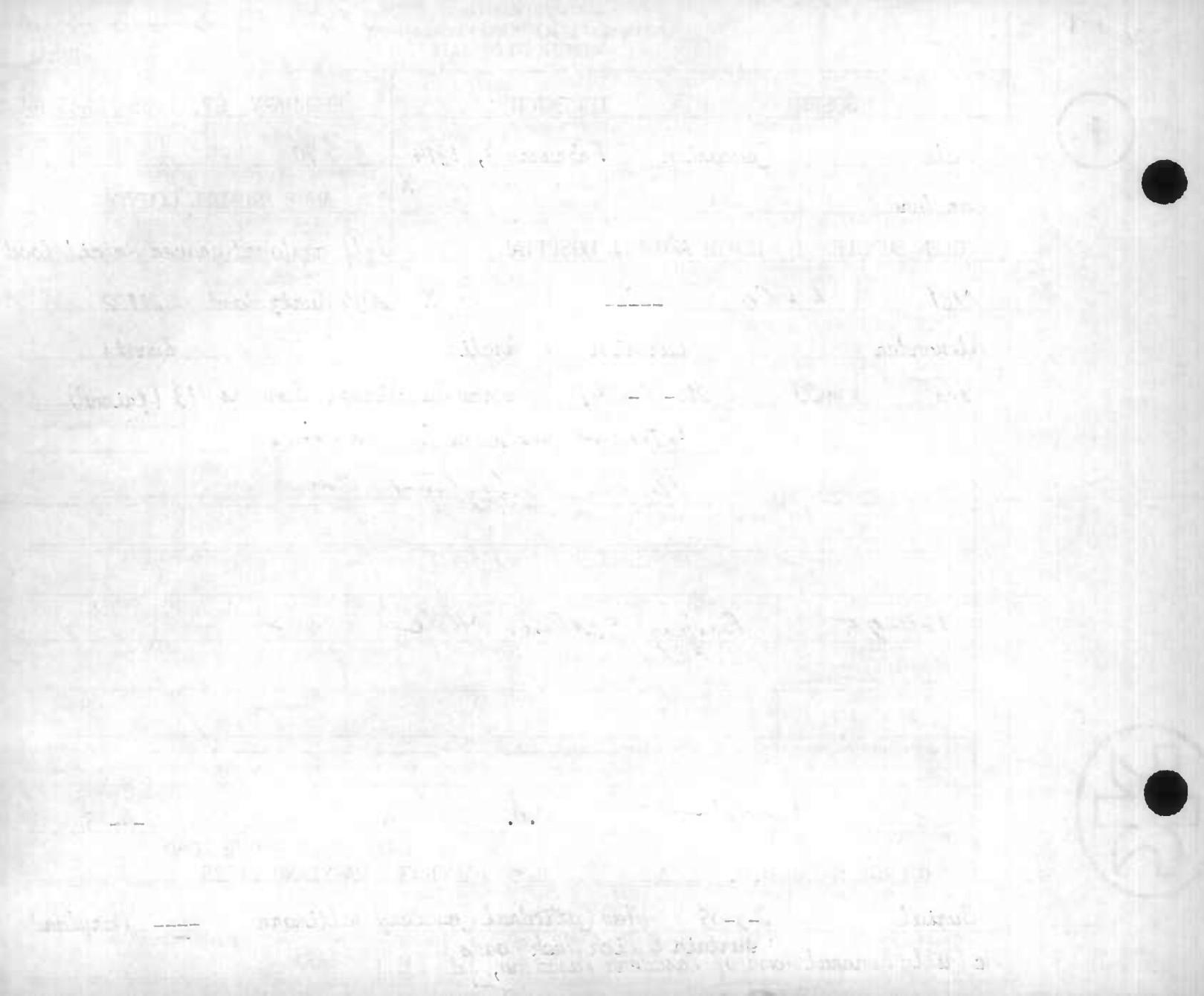
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "Yes" to indicate any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5 0 3 4 3 4	EST				
1 - STATE REGISTRAR			REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR		
JOSEPH		J	LUKENICH				FEBRUARY 02, 1985						0845 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS.		
Male		Caucasian		Month Day Year February 3, 1914			70 YRS			MONTHS DAYS			HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			ANNE ARUNDEL COUNTY MD.					
Maryland		USA													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL							Self employed grocer			Retail food			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			13f. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Md.		AA Co					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2034 Kuntz Road 21122					
14. FATHER'S NAME		FIRST	MIDDLE	LAST			15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Alexander				Lukenich			Amelia					Zunats			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT			16d. ADDRESS								
Yes		1699		216-01-0247			Andrew Hutchinson Same as #13 (friend)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) extensive metastatic carcinoma															
DUE TO, OR AS A CONSEQUENCE OF (b) massive mediastinal ca															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION 1-11-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bulky scalene Node							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost sow the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) saw the body after death.															
22b. SIGNATURE <i>J. S. L.</i>		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 2-4-85									
22e. PHYSICIAN'S NAME GEORGE S. LANE, M.D.		22f. ADDRESS 4300 BELLE GROVE ROAD BALTIMORE, MARYLAND 21225													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-5-85		23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cemetery Baltimore			23d. LOCATION CITY OR TOWN		COUNTY		STATE Maryland				
24. FUNERAL DIRECTOR Mc Cully Funeral Home of Pasadena, Md		24b. ADDRESS Mountain & Neck Roads		25a. DATE REC'D. BY REGISTRAR FEB 7 1985			25b. REGISTRAR'S SIGNATURE								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 2 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If items 21 & 22 are marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0 3 4 3 5					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR			
DAVID			R.		MARINE	2-7-85					6:48 P.M.				
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)				
Male			Negro		5 7 07						77	YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		8.			MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			U.S.A.									Anne Arundel			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Annapolis			Anne Arundel General Hospital			Laborer									
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
Maryland			Anne Arundel	Annapolis				218 Gross Ave. 21401							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
John			F.		Marine	Amelia					Kane				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			214-05-1771			Ardie Marine			21401 218 Gross Ave. Annapolis, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
IMMEDIATE CAUSE (a)			<i>organic brain syndrome</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>cerbrovascular disease</i>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(c)												
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.															
Deep mesial decubitus ulcer, urinary tract infection															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) this hospital attended the deceased from <u>1982</u> , 19_____, to <u>1985</u> , 19_____, that (we) lost saw the deceased alive on <u>2-5</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>G. Mitchell</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>2-8-85</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>G. Mitchell</i>			22e. ADDRESS <i>205 Ridge Rd Annapolis MD</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/13/85			23c. NAME OF CEMETERY OR CREMATORIAL Malone UM Cemetery			23d. LOCATION CITY OR TOWN Madison			COUNTY Dorchester	STATE Md.		
24. FUNERAL DIRECTOR NAME Boardley Funeral Home			ADDRESS 812 Hubbard St. Camb., Md.			23e. DATE REC'D. BY REGISTRAR FEB 13 1985			23f. REGISTRAR'S SIGNATURE <i>Boardley</i>						

A



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (by the funeral director), page 1 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8503436								
												REG. NO.								
1 - FOR STATE REGISTRAR			2d. DATE OF DEATH									2b. HOUR								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	Feb. 25, 1985			MONTH	DAY	YEAR									
EILEEN			F.		MCCRACKEN															
3. SEX <b>Female</b>			4. RACE <b>White</b>		5. DATE OF BIRTH MONTH 5 DAY 2 YEAR 34		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		50			MONTHS	DAYS	HOURS	MIN.							
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b>			10. CITY OR TOWN OF DEATH <b>Brooklyn</b>									11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>604 Old Riverside Road</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Office Worker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Telephone</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Brooklyn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>604 Old Riverside Road 21225</b>										
14. FATHER'S NAME FIRST <b>Marrio</b>			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST <b>Victoria</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>216-30-2239</b>		17. INFORMANT <b>Blair G. McCracken Jr.</b>			ADDRESS <b>Same as 13e</b>												
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure.</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last												(b) <b>Ca of Sepsis &amp; Metabolic</b>								
{ DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22b. SIGNATURE <i>Mosser Traimor d.</i>								
22c. DEGREE <i>MD</i>												22d. DATE SIGNED <i>1985</i>								
22e. ATTENDING PHYSICIAN <input type="checkbox"/>			22f. MEDICAL DIRECTOR <input type="checkbox"/>			22g. STAFF PHYSICIAN <input type="checkbox"/>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2/28/85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Redeemer Cem.</b>		23d. LOCATION CITY OR TOWN <b>Balto</b>		COUNTY	STATE										
24. FUNERAL DIRECTOR NAME <b>George Gonce 4001 Ritchie Hwy Balto Md</b>			ADDRESS <b>21225</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Laurie Pendleton</i>													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24-hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR		
1 DECEASED NAME FIRST MIDDLE LAST			2b DATE OF DEATH MONTH DAY YEAR							2b HOUR		
Elizabeth Goodhand McWilliams			2 11 85							6 A.M.		
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS	
					6 7 15			69 YRS			MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				
10 CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a USUAL OCCUPATION Homemaker			12b KIND OF BUSINESS OR INDUSTRY Home				
13a. STATE MD			13b. COUNTY A.A.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 161 Franklin Street 21401				
14. FATHER'S NAME Charles Luther Goodhand			15. MOTHER'S MAIDEN NAME Roselynne									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b SOCIAL SECURITY NO. -		17. INFORMANT William J. McWilliams			ADDRESS				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			BIRTH MYOCARDIAL INFARCTION									
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/18/84 to 2/11/85, that (I) last saw the deceased alive on 2/11/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (not) view the body after death.												
22b. SIGNATURE S. P. WATKINS MD			DEGREE		22c. DATE SIGNED 2/11/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. P. WATKINS MD			22e. ADDRESS 51 Franklin St., Annapolis, MD 21401									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 14, 1985		23c. NAME OF CEMETERY OR CREMATOR Trinity Episcopal			23d. LOCATION CITY OR TOWN Upper Marlboro		23e. COUNTY STATE P.G. MD		
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel, Annapolis, MD			ADDRESS		25a. DATE REC'D. BY REGISTRAR FEB 14 1985			25b. REGISTRAR'S SIGNATURE Julia K. Johnson				



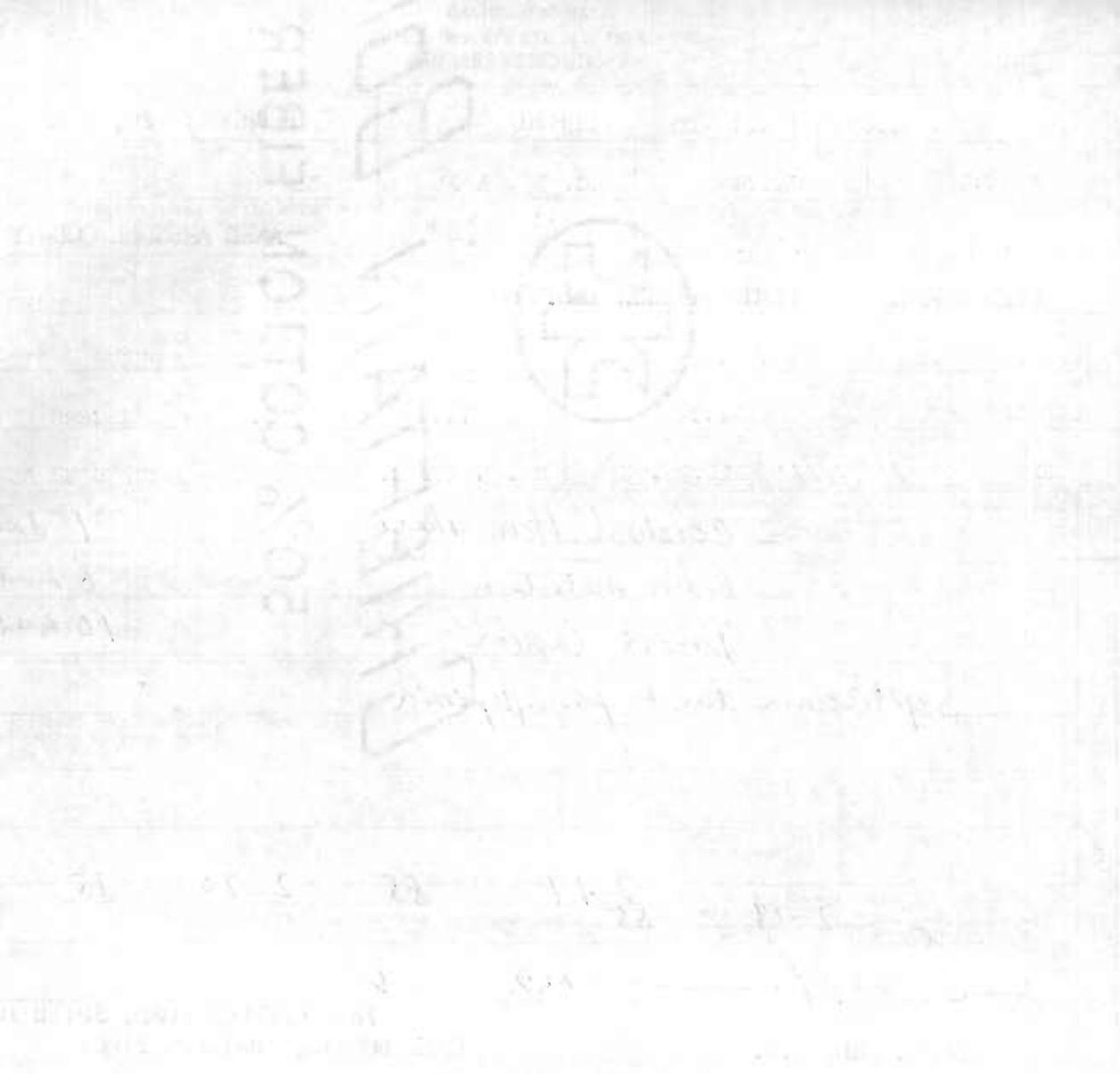
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon/papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

### MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85 03438 EST				
												REG. NO.				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR									2b HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			FEBRUARY 20, 1985			210 AM				
CHARLOTTE ELIZABETH MEDFORD																
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.				
FEMALE		WHITE		DEC. 25, 1931			53 YRS									
7a BIRTHPLACE COUNTRY MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.									
10 CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b KIND OF BUSINESS OR INDUSTRY OWN HOME									
13a STATE MARYLAND		13b COUNTY ANNE ARUNDEL		13c. CITY OR TOWN GLEN BURNIE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1011 SOMERSET DRIVE 21061						
14 FATHER'S NAME ANDREW		15 MOTHER'S MAIDEN NAME ELLEN														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 1111111111		17 INFORMANT MR. LEROY E. MEDFORD (husband) SAME AS #13			18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
18. CAUSE OF DEATH: Enter only one cause per line for 1(a), 1(b), and 1(c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH: Enter only one cause per line for 1(a), 1(b), and 1(c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH: Enter only one cause per line for 1(a), 1(b), and 1(c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH: Enter only one cause per line for 1(a), 1(b), and 1(c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH: Enter only one cause per line for 1(a), 1(b), and 1(c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			1 day			
													6 month			
													10 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET			21g CITY OR TOWN			21h COUNTY		21i STATE				
22a I certify that (I) (this hospital) attended the deceased from 2-17, 1985, to 2-20, 1985, that (I) (we) last saw the deceased alive on 2-19, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.																
22b SIGNATURE <i>M.S. ISU, M.D.</i>												22c. DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061														
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE FEB. 23, 1985		23c NAME OF CEMETERY OR CREMATORIAL PARK GLEN HAVEN MEM. PARK			23d LOCATION CITY OR TOWN GLEN BURNIE, MARYLAND									
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME, GLEN BURNIE, MD.		ADDRESS		25a DATE REC'D. BY REGISTRAR FEB 22 1985			25b REGISTRAR SIGNATURE <i>Laurel Dawson, R.N.</i>									
BP _____																
DHMH - 16 60M 7/84 (VRA IS, 4)																

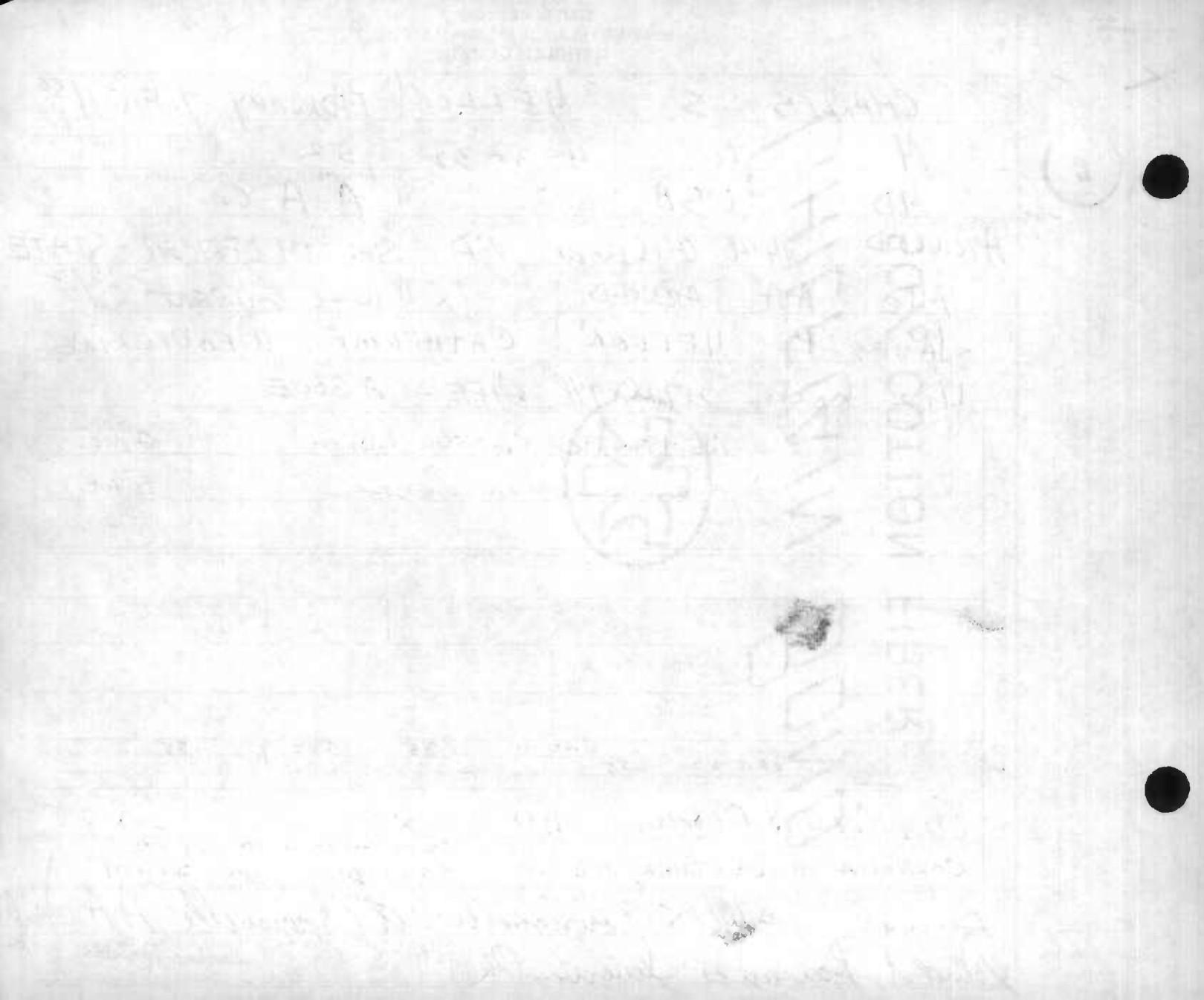


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon严厉. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301-767-2100.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8503139											
												REG. NO.											
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR											
			CHARLES S MELLON						FEBRUARY 7, 1985			11:50 PM											
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN.										
M		W		4-3-32			52																
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH																
MD		USA					A.A.Co.																
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
ARNOLD		1440 GILBERT RD										SAFETY OFFICER - STATE											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21012										
MD		AA		ARNOLD						1440 GILBERT Rd													
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																					
JAMES P. MELLON		CATHERINE WEAUERKING																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
Yes Korea		217288948		WIFE - ABOVE						2 MO.													
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												METASTATIC CANCER LUNG											
												5 MO.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA LUNG											
												DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
												YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE											
22a. I certify that (I) (this hospital) attended the deceased from JAN 1 1985 to FEB 7 1985, that (I) (we) last saw the deceased alive on JAN 22 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE CORNERIA M. DETTMER, MD												DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CORNERIA M. DETTMER, MD												22e. DATE SIGNED 2-8-85											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)												23b. DATE 3/11/85			23c. NAME OF CEMETERY OR CREMATORIAL LOCATION TOWN CITY COUNTY STATE			23d. DATE REC'D. BY REGISTRAR FEB 11 1985			23e. REGISTRAR'S SIGNATURE John Henderson		
24. FUNERAL DIRECTOR NAME Robert J. Bananas Lewellen Ph												ADDRESS											



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03440

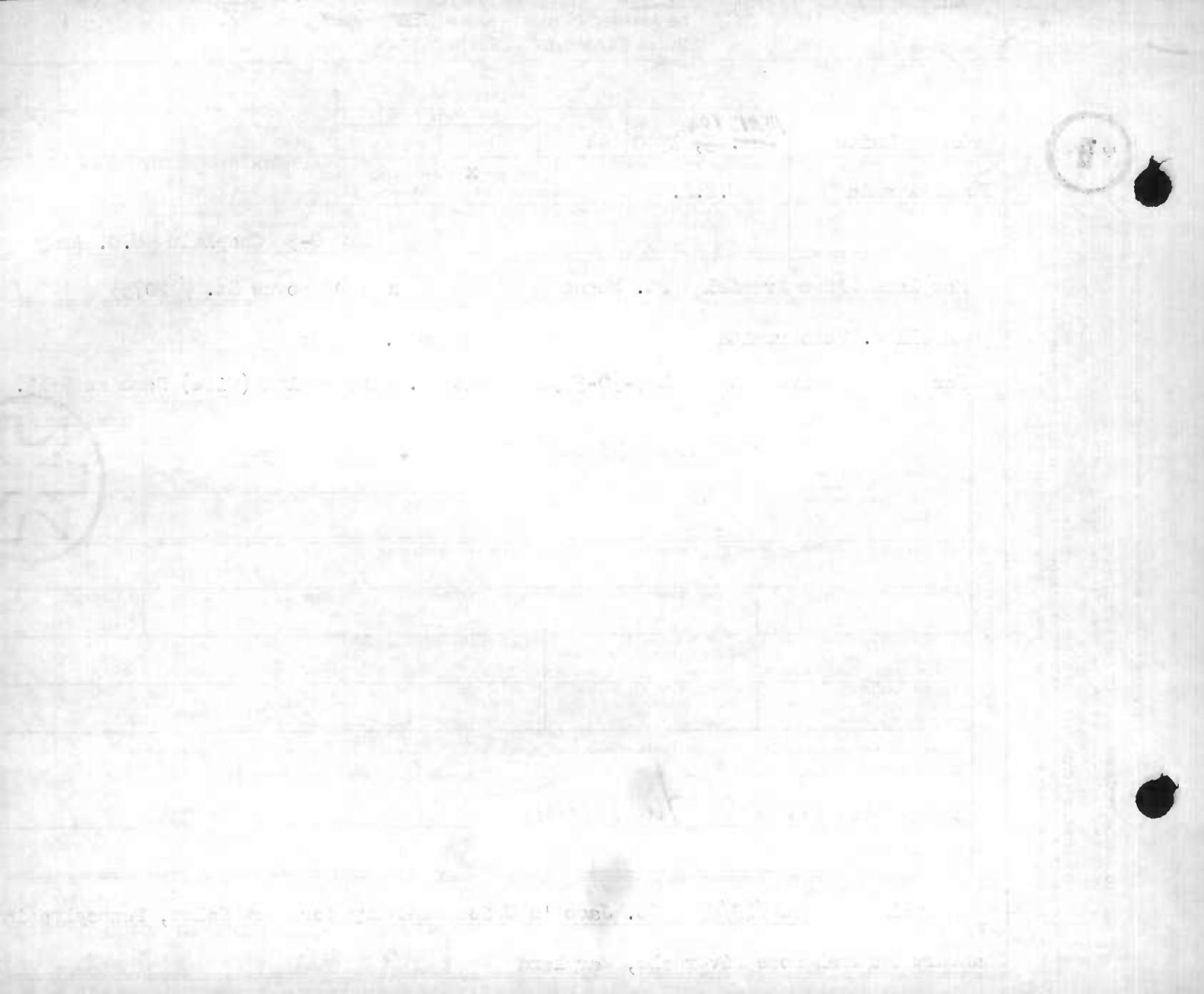
FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN EST. MONTH DAY YEAR	2b. HOUR	
		Mildred	Dorothea	Merrill	Feb 15/1985	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.		
Female	White	June 23, 1936	48 yrs.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
New Hampshire		U.S.A.				Anne Arundel County, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Severn		7904 Elberta Drive			Budget Annyl.		Civil Serv.
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Anne Arundel	Severn			7904 Elberta Drive	21144
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			
George			Randall	Dot		LAST Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) [IF YES, GIVE WAR OR DATES]		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No None		003.24.2289		William E. Merrill Husband		same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Gunshot Wound of Head</u> DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last</u> . (b) DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY APPROX. MONTH DAY YEAR 2:30 P.M. 2/15/85	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self-inflicted wound				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bathroom	21f. LOCATION STREET 7904 Elberta Dr., Severn, Anne Arundel, Md.		CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) ACTUAL SIGNATURE <u>Dennis F. Smyth, M.D.</u> M.D. Assistant MEDICAL EXAMINER							
DATE SIGNED <u>2/16/85</u>							
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS		111 Penn St.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL Security Proc. Inc.		23d. LOCATION CITY OR TOWN Catonsville		COUNTY Balto. Md. STATE
Cremation		Feb 19, 1985					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR FEB 19 1985		25b. REGISTRAR'S SIGNATURE <u>H.B. Duran</u>			
Singleton Funeral Home, Glen Burnie, Md. 21061							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 1 TO THE FILER BY DECORUM PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										0 3 4 4 1	
1. DECEASED NAME FIRST MIDDLE LAST												REG. NO.	
1. SEX Male		4. RACE White		5. DATE OF BIRTH <i>10/10/1913</i>	YEAR <i>1913</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>44</i>	7. IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	MONTH MIN.	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	MONTH <i>2</i> DAY <i>15</i> YEAR <i>1985</i>	2b. HOUR <i>M</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				2c. DATE PRONOUNCED DEAD <i>2/ 15/ 1985</i>			2d. HOUR <i>7:15 P.M.</i>		
10. CITY OR TOWN OF DEATH Severn		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>7904 Elberta Drive</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>LTC O-5 Chaplain</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Army</i>				
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Ft. Meade		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>7809 Boyce St. / 20755</i>					
14. FATHER'S NAME FIRST Russell J. Messersmith		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST Anna M. Menges							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Active Duty		17. INFORMANT Ruth P. Messersmith (Wife)				ADDRESS Same as # 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gunshot Wounds of Chest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY APPROX. MONTH DAY YEAR <i>2:30 P.M. 2/ 15/ 1985</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>subject shot</i>				21e. LOCATION STREET <i>7904 Elberta Dr.</i> CITY OR TOWN <i>Severn</i> , Anne Arundel, Md. COUNTY STATE					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>bathroom</i>		21g. TITLE (SPECIFY) <i>Dennis F. Smyth, M.D. Assistant</i>			21h. MEDICAL EXAMINER						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i>		DATE SIGNED <i>2/16/85</i>											
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS <i>111 Penn St.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb/19/85		23c. NAME OF CEMETERY OR CREMATORIY St. Jacob's Union Cemetery		23d. LOCATION CITY OR TOWN York		COUNTY New Salem, Pennsylvania		STATE			
24. FUNERAL DIRECTOR NAME Chambers Funeral Home Riverdale, Maryland		ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>FEB 21, 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pender</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked **(a)**, then **(b)** is a non-fatal injury, or other traumatic event. If medical examiner must be notified, mark **(b)**.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										EST	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
CAROL Ann MILLER						FEBRUARY 8, 1985			504 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		1 6 49			36 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland		U.S.A.					ANNE ARUNDEL COUNTY				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL								Secretary	
13. STATE		14. COUNTY		13a. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
Maryland		Baltimore		Baltimore			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3900 McDowell Lane 21227	
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY	
Max		G.		Bennett			Dorothy			Pasadena, Md 21122	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			Harold K. Solley 8432 Garland Road			Insurance Co.	
No		217-56-3174									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 1a) <i>Hepatic Failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF 1b) <i>Metastatic Breast Cancer</i>										1 month	
DUE TO, OR AS A CONSEQUENCE OF 1c) <i></i>										18 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Brain tumor</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (i) this hospital attended the deceased from <i>1-27</i> to <i>19-85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (ii) (we) did not view the body after death.										<i>2-8 19-85 2-8 19-85</i>	
22b. SIGNATURE <i>Lynne</i>										22c. DEGREE M.D.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M.D.										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061										22f. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY/TOWN Balto			23e. COUNTY STATE	
Burial		2/11/85		Cedar Hill Cemetery						A.A. Md.	
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md		25a. DATE REC'D. BY REGISTRAR FEB 13 1985									
		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									

WILSON, JAMES H.

1920-1921, 1922-1923

1921

SOCIAL SECURITY

EMP. SECURITY

1921-1922

1921-1922

1921-1922

1921

1921

1921-1922

1921-1922

1921-1922

1921-1922

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 5 0 3 4 4 3	EST								
												REG. NO.									
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST LILLIE			MIDDLE Self			LAST MILLER			2a. DATE OF DEATH MONTH FEBRUARY			DAY 7, 1985		2b. HOUR 645 P M	
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH March			DAY 29, 1925			6. AGE (IN YEARS LAST BIRTHDAY) YRS. 59			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.												
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home												
13a. STATE Maryland			13b. COUNTY AnneArundel			13c. CITY OR TOWN SevernaPark			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 1300 Oak Road			21146						
14. FATHER'S NAME FIRST Truman			MIDDLE Self			LAST			15. MOTHER'S MAIDEN NAME FIRST Lillie			MIDDLE ROSS			LAST griffin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None			17. INFORMANT James A. Miller			ADDRESS Husband			Same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF CIRRHOSIS OF THE LIVER, GI BLEEDING																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF GASTRODUODENAL ULCERS																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																					
19a. DATE OF OPERATION 2-3-85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BLEEDING GASTRODUODENAL ULCER			20a. AUTOPSY? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE Ferdinand C. Rodriguez			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/8/85												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FERDINAND C. RODRIGUEZ, M.D.			22e. ADDRESS NORTH ARUNDEL HOSPITAL																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Feb. 8, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Security Process, Inc			23d. LOCATION CITY OR TOWN Catonsville			COUNTY Balto		STATE Md.							
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, Maryland									25a. DATE REC'D. BY REGISTRAR FEB 11 1985			25b. REGISTRAR'S SIGNATURE R. J. Rendell									

2000 copies

Wickham



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										03444			
1 - FOR STATE REGISTRAR			REG. NO.										
I. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
Carrie		B.		Mitchell	2	16	85			2:20 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
Female		White		MONTH 1	DAY 13	YEAR 1894	91						
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Kentucky		U.S.A.				Anne Arundel							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		130 West Edgevale Road		Housewife		Home Maker							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		A.A.		Baltimore		130 West Edgevale Road 21225							
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME									
Richard			Brady	Mattie									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		212-07-9260		Mabel Mitchell		Same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 20 to APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Failure</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>HASCUD, atrial fibrillation</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>9/11</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		6/20 19 80		to 2/16 19 85									
22b. SIGNATURE <u>S. Mundra</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/18/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SURYA P. MUNDRA</u>		22e. ADDRESS 203 E. PATAPSCO AVE BALTIMORE 21225											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>2/19/85</u>		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN Balto		COUNTY	STATE				
24. FUNERAL DIRECTOR <u>George J. Gonce</u> 4001 Ritchie Hwy Balto Md				25a. DATE REC'D. BY REGISTRAR <u>FEB 19 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>							



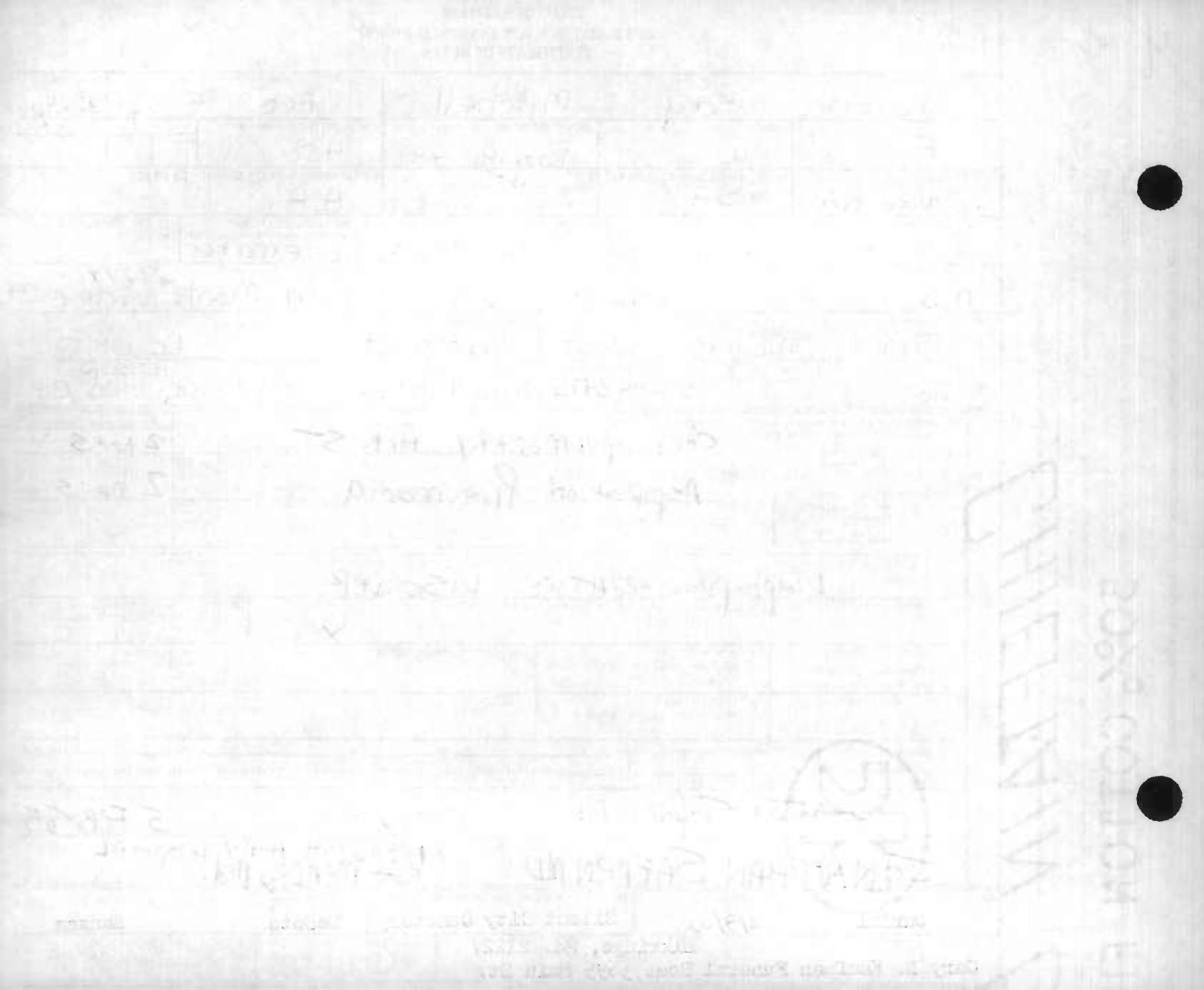
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										B 5 03 45			
										REG. NO.			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)  Sharon Kay Mitchell			MIDDLE		LAST			Feb 5 85		3:24 PM			
3. SEX  F		4. RACE  W		5. DATE OF BIRTH MONTH DAY YEAR  May 9 44			6. AGE (IN YEARS LAST BIRTHDAY)  40		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 yrs HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  Lawrence KA		7b. CITIZEN OF WHAT COUNTRY?  USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH  A.A.		MD.				
10. CITY OR TOWN OF DEATH  Jessup		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  Kimbrough Army Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  homemaker			12b. KIND OF BUSINESS OR INDUSTRY  Montevideo Ct.						
13a. STATE  MD		13b. COUNTY  A.A.		13c. CITY OR TOWN  Jessop			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS  7509 Montevideo Ct.				
14. FATHER'S NAME FIRST James		MIDDLE Thomas		LAST West			15. MOTHER'S MAIDEN NAME FIRST Margaret		MIDDLE		LAST Lawler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Alan Mitchell			ADDRESS 7509 Montevideo Ct.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c)										2 hours			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Lymphoproliferative disorder</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Jonathan Safren MD</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5 FEB 85</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)  <u>JONATHAN SAFREN MD</u>		22e. ADDRESS  KIMBROUGH ARMY HOSPITAL FORT MEADE, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 2/9/85		23c. NAME OF CEMETERY OR CREMATORIAL Silent City Cemetery		23d. LOCATION CITY OR TOWN DeSoto		COUNTY		STATE Kansas			
24. FUNERAL DIRECTOR NAME Gary L. Kaufman Funeral Home		ADDRESS 5695 Main St.		Elkridge, Md. 21227		25a. DATE REC'D. BY REGISTRAR FEB 11 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson Randall</u>					

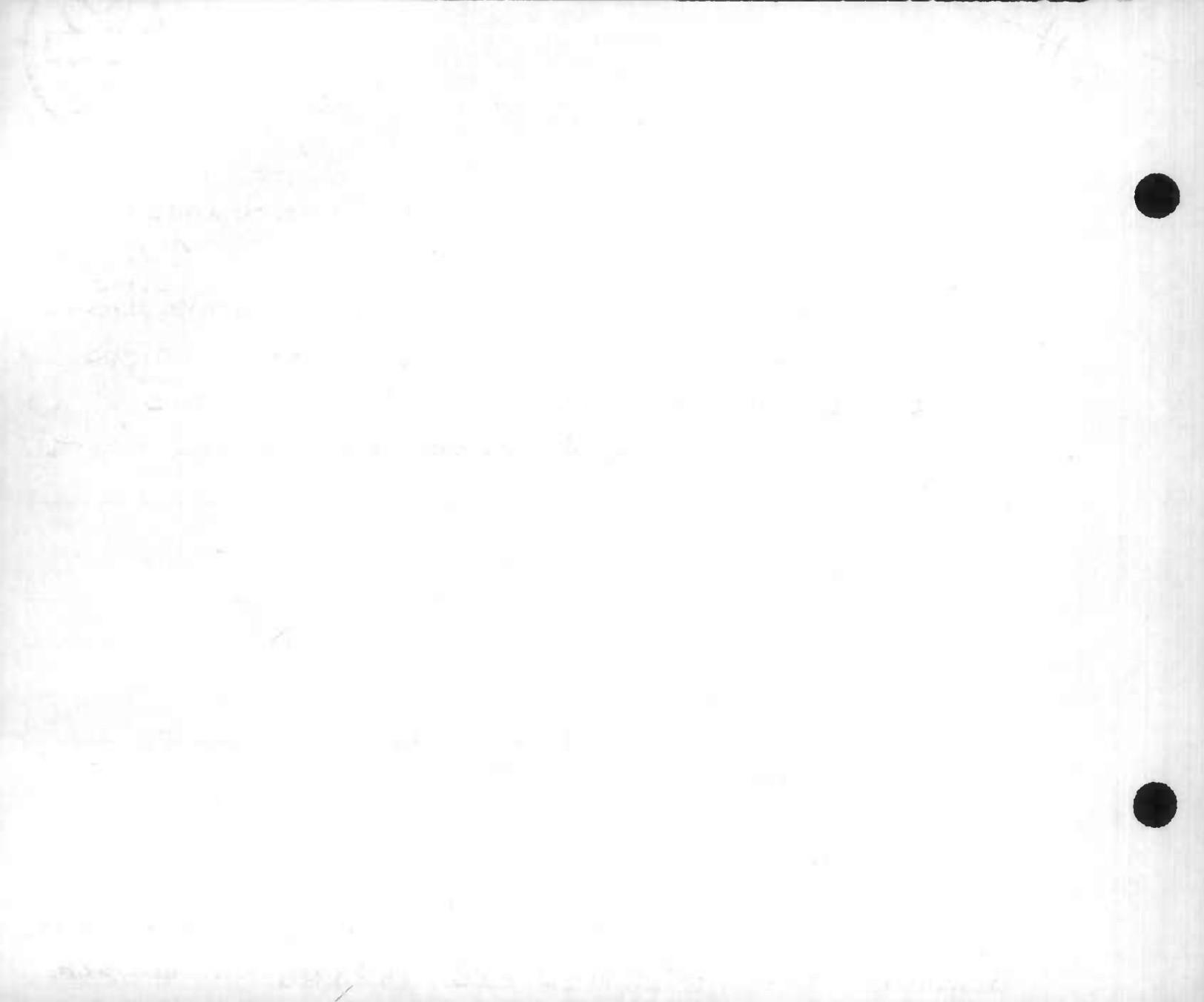


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or items 18 shows any injury, or other traumatic event, the medical examiner must be通知ed of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										B 5 0 3 4 4 6					
										REG. NO.					
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN R.			LAST Monday			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
												2/21/85		2 PM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male			White			8/31/25									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland			USA						Anne Arundel MD						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Annapolis			Anne Arundel General Hospital						Civil Service						
13a. STATE			13b. COUNTY			14. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		21403	
MD			A.A.			Annapolis						310 Chesapeake Avenue			
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			ADDRESS						
Albert			F. Monday			Bessie			B. Phipps						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			same as #13			
Yes (WWII)			216-18-5163			Lucille V. Fisher-									
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										4 months					
DOUE TO, OR AS A CONSEQUENCE OF (b)															
DOUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 2/18/85 to 2/21/85, that (I) (we) last saw the deceased alive on 2/20/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE EW Coley										DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
EW Coley III			51 FRANKLIN ST ANNAPOLIS MD.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTYS STATE				
Burial			Feb 25 1985			Hillcrest			Annapolis AA		MD				
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Taylor Funeral Chapel - Annapolis, MD									FEB 26 1985		Julia Davidson-Pandell				

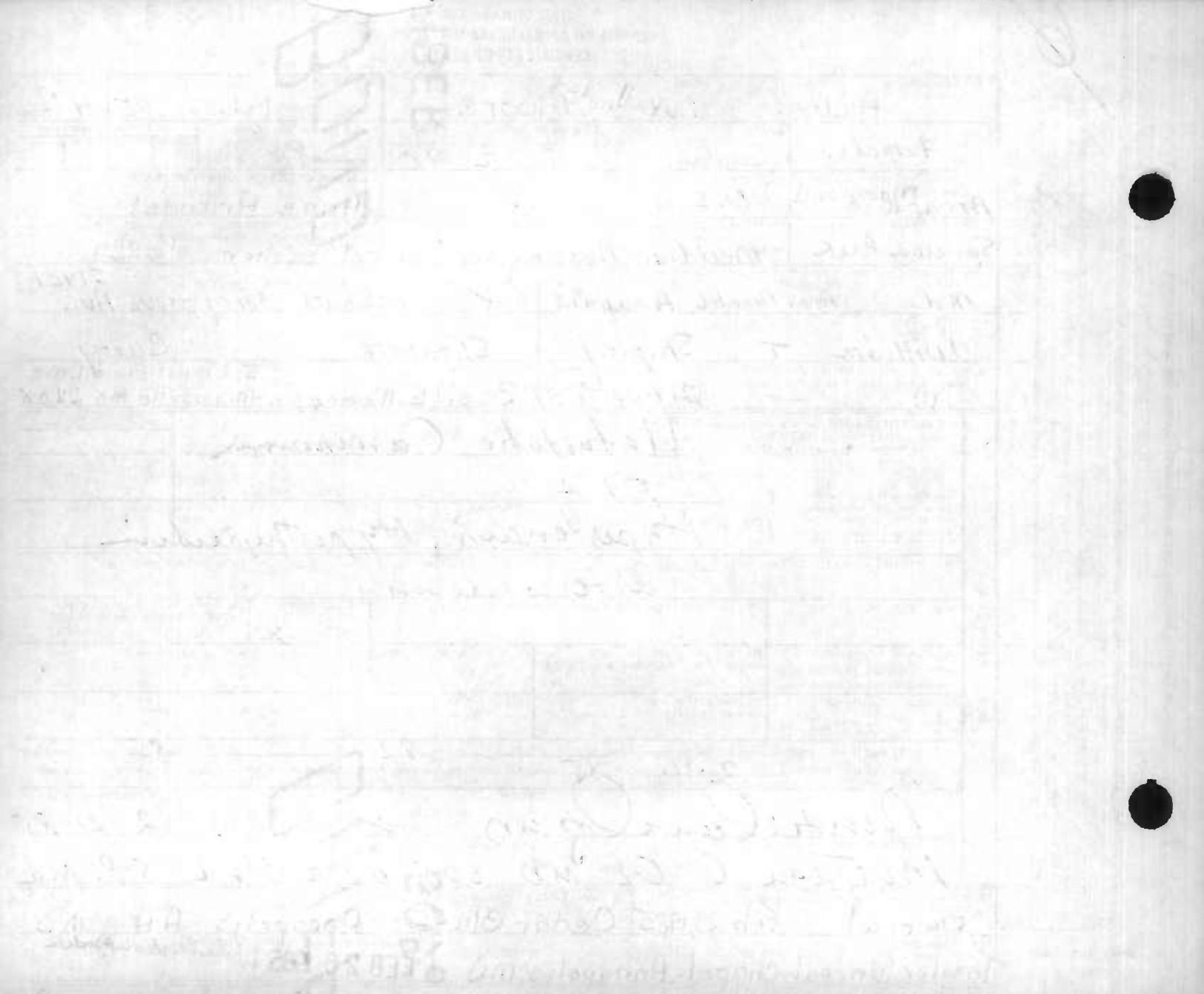


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
REG. NO. 850344														
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. HOUR								
Audrey Durall Shipley Moore						Feb. 21 85 4 <sup>17</sup> PM								
3. SEX Female			RACE Caucas.			5. DATE OF BIRTH MONTH 9 DAY 2 YEAR 98			6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland Annapolis			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Severna Park			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center			12a. USUAL OCCUPATION Ret Teacher			12b. KIND OF BUSINESS OR INDUSTRY Public School					
13a. STATE Md.			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 101 South Cherry Grove Ave 21401		
14. FATHER'S NAME William T Shipley						15. MOTHER'S MAIDEN NAME Elizabeth Curry								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO			16b. SOCIAL SECURITY NO. 214-30-7357			17. INFORMANT Basil E. Moore Jr. - Millersville MD			ADDRESS 512 Point Field Drve 21108			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma														
DUE TO, OR AS A CONSEQUENCE OF (b) TIA														
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension, Hyperthyroidism, Arterio sclerosis														
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19 82 to 19 83, that (I) (we) last saw the deceased alive on 2/21/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Mustafa C Oz						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/21/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS Cedar Bluff								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 23, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Bluff			23d. LOCATION CITY OR TOWN Annapolis			23e. COUNTY Anne Arundel MD		
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD			ADDRESS						25. DATE REC'D. BY REGISTRAR FEB 26 1985			25e. REGISTRAR'S SIGNATURE John Harbinson		
												21186 STATE		

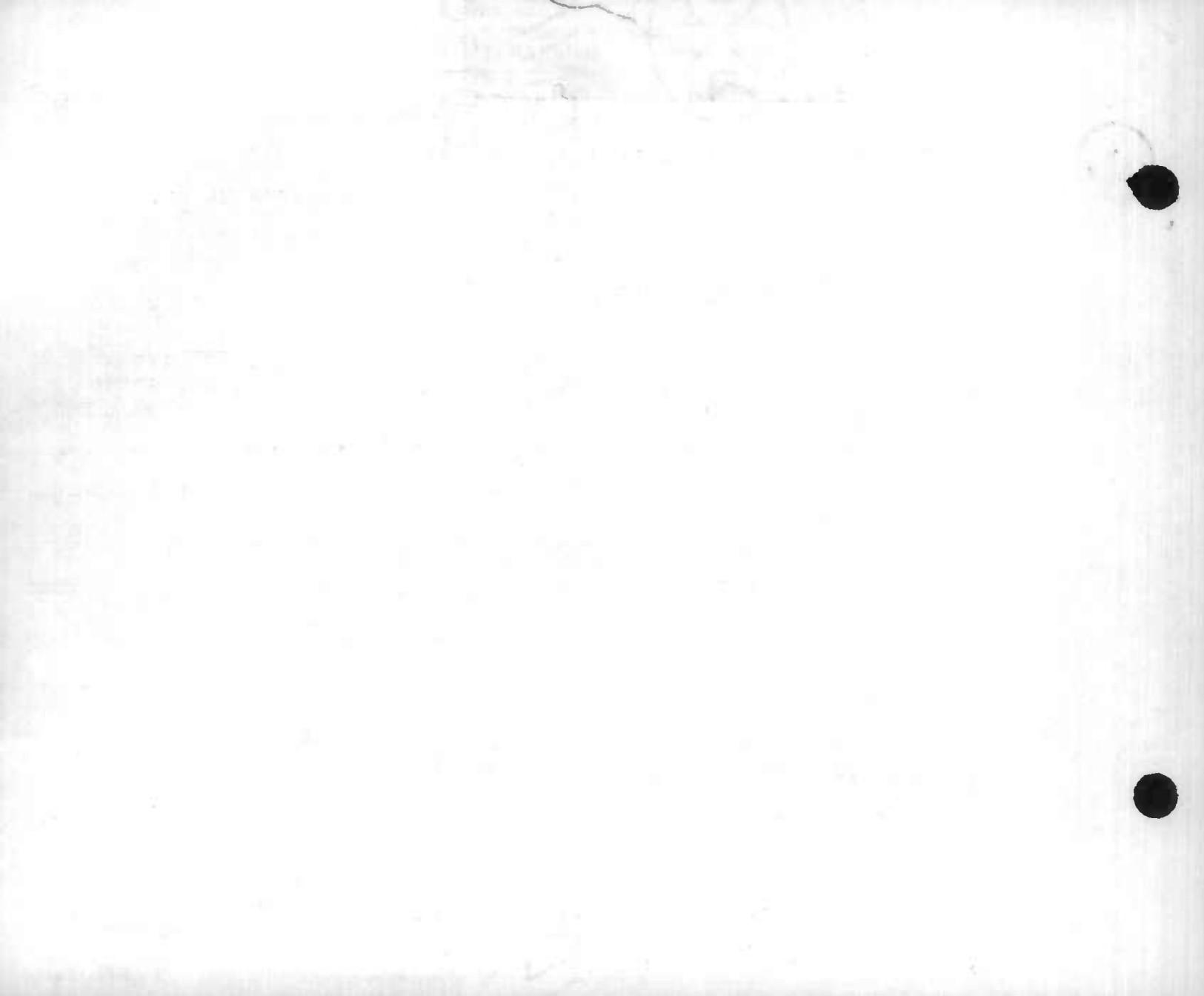


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 3 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8503448	
												REG. NO.	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Ida M. Moore						2-19-85			7:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
FEMALE		1 CAUCASIAN		3 25 01			83 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND		USA					ANNE ARUNDEL CO.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
ANNAPOLIS		ANNE ARUNDEL GENERAL		HOUSEWIFE									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MARYLAND		ANNE ARUNDEL		ANNAPOLIS						130 HEARNE RD. 21401			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
LEROY		IDA JONES											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS BOX 175			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		24576-7400		AUDREY M. BROOKS RIVA, MD. 21140									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia exhalism</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>severe cerebral phlebitis</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>osteoporosis</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>osteoporosis</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (this hospital) attended the deceased from 2-19-82, 19, to 2-19, 19, 85, that (s/he) lost saw the deceased alive on 2-19-85, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (s/he) did not view the body after death.													
22b. SIGNATURE <i>G. Mitchell MD</i> DEGREE												22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>G. Mitchell</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS			2-19-85 21401					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE BURIAL 2-23-85		23c. NAME OF CEMETERY OR CREMATORIES RALEIGH MEMORIAL			23d. LOCATION CITY OR TOWN RALEIGH COUNTY WAKE CO. NORTH STATE						
24. FUNERAL DIRECTOR NAME ROBERT E. EVANS		1212 WEST STREET ADDRESS ANNAPOLIS MD. 21401			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRATION NUMBER					



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-1 RETAIN PAGE 4 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 03449	
1- STATE REGISTRAR		2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> MONTH DAY YEAR 19 M											
1. DECEASED NAME (TYPE OR PRINT)		FIRST LOUISE		MIDDLE MARGARET		LAST MOURIS				2b. HOUR 19 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10/29/1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County		10. DATE PRONOUNCED DEAD 2-21-1985 10 AM		11. HOUR 24 HOUR			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a. STATE Pennsylvania		13b. COUNTY - - -		13c. CITY OR TOWN Philadelphia		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3311 S. Keswick Place		12b. KIND OF BUSINESS OR INDUSTRY 999999 19114			
14. FATHER'S NAME FIRST Joseph		MIDDLE Fedalen		LAST		15. MOTHER'S MAIDEN NAME FIRST Kate		MIDDLE		LAST Laudenslager			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 173.05.7121		17. INFORMANT Paul C. Mouris		ADDRESS 207 Nomini Drive Arnold, Md. 21012							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>James E. Wheeler</i>		TITLE (SPECIFY) M.D. <i>Jep.</i> MEDICAL EXAMINER										DATE SIGNED 2-27-85	
EXAMINER'S NAME James E. Wheeler, M.D. (TYPE OR PRINT)		ADDRESS 910 Primrose Rd, Annapolis, 21403											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/1/1985		23c. NAME OF CEMETERY OR CREMATORIAL Green Mount Crematory		23d. LOCATION CITY OR TOWN Baltimore		COUNTY Maryland		STATE			
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc., Balto., Md. 21222		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAR 1 1985		25b. REGISTRAR'S SIGNATURE <i>BP</i>							
999999		CHMH - 17 (VR A15 ME (5))											
20M 4/82													

929 MAC 1

882 T 941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 3503450	EST	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR P M		
FRANTS			H.		NIELSEN	FEBRUARY 8, 1985						12:05 M		
3. SEX <i>Male</i>			4. RACE <i>White</i>		5. DATE OF BIRTH <i>Feb. 11, 1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i>						IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Denmark</i>			7b. CITIZEN OF WHAT COUNTRY? <i>Denmark</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County MD.</i>							
10. CITY OR TOWN OF DEATH <i>GLEN BURNIE</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>NORTH ARUNDEL HOSPITAL</i>		12a. USUAL OCCUPATION <i>Caret Engineer</i>						12b. KIND OF BUSINESS OR INDUSTRY <i>Shipper</i>			
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. MOTHER'S NAME <i>Juliana</i>		15. MOTHER'S MAIDEN NAME <i>Etta Nielsen</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>212-20-79361</i>		17. INFORMANT <i>Mrs. Etta Nielsen (Same as 13e.)</i>		ADDRESS <i>21061 7805 Americana Circle Apt. 202</i>							
III. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b) <i>Lung sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of esophagus</i>												APPROXIMATE INTERVAL BETWEEN DISEASE AND DEATH <i>2 months</i> <i>2 years</i> <i>2 years</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <i>At work</i>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1929</i> , 19_____, to <i>present</i> , 19_____, shot (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE <i>Sidney R. Gehlert, M.D.</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SIDNEY R. GEHLERT, M.D.</i>			22e. ADDRESS <i>4700 PENNINGTON AVENUE BALTIMORE, MARYLAND 21226</i>						22f. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22g. DATE SIGNED <i>Feb 13 1985</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2/11/1985</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Memorial Park, Glen Burnie Anne Arundel Md.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE							
24. FUNERAL DIRECTOR <i>Mountain &amp; Rock Neck Ras. Fully Funeral Home of Pasadena</i>			24b. FUNERAL DIRECTOR <i>Pasadena, Md. 21122</i>		25a. DATE REC'D. BY REGISTRAR <i>Feb 13 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Lia Davidson-Pandell</i>							
DHMH - 16 60M 7/84 (VRA 15, 4)														



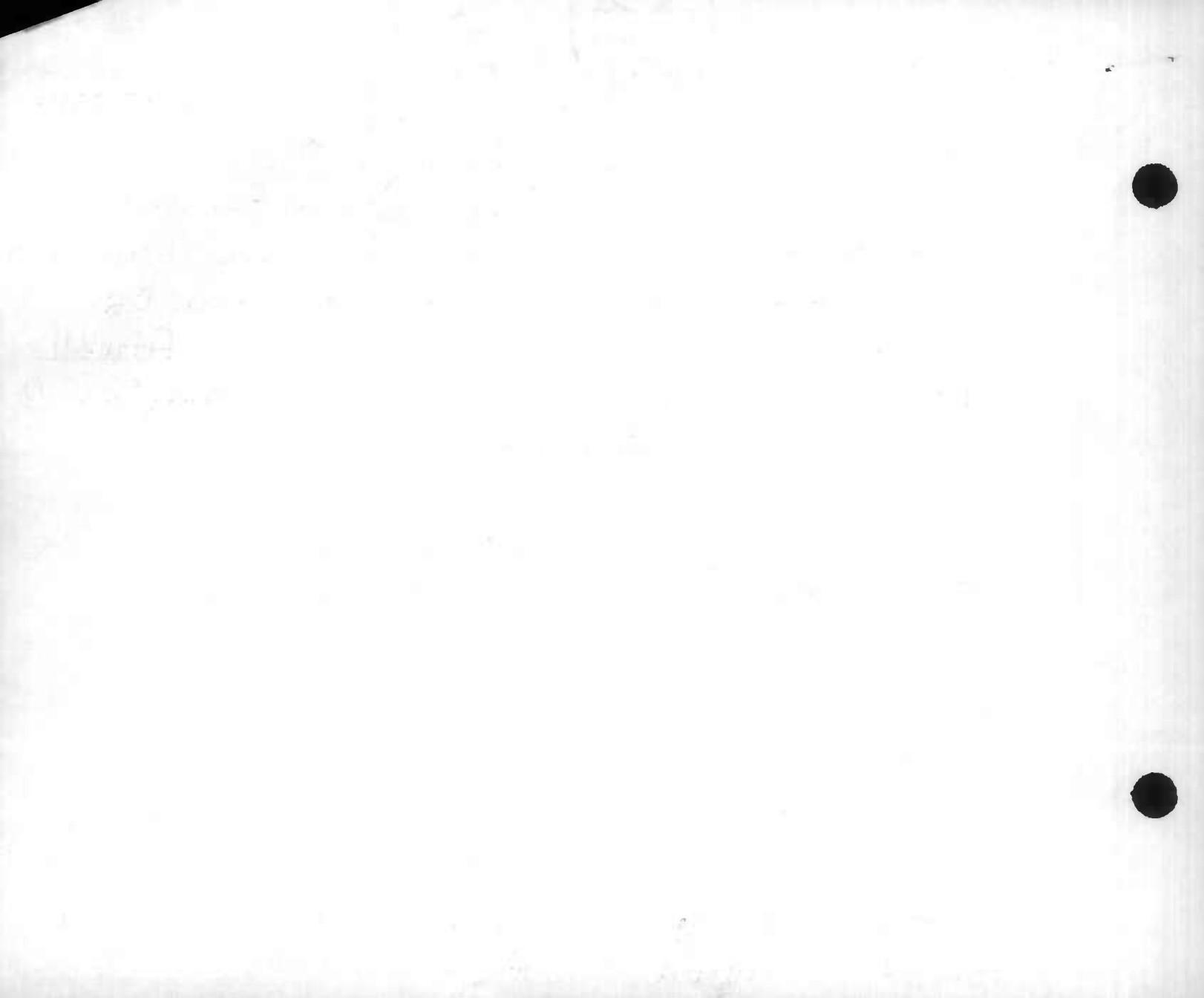
2070X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 & 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03451										
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
			Elizabeth							Nieman		02		16	85	2:25 P.M.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		# UNDER 24 HRS						
female			white			MONTH 6 DAY 7 YEAR 1895			89 YRS.			MONTHS		DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH								
U.S.			U.S.						Anne Arundel MD.			CROFTON, MD								
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE						13b. COUNTY					
CROFTON, CONVALESCENT CENTER			HOME MAKER			Household			MD						A.A.					
14. FATHER'S NAME FIRST ROBERT MIDDLE ROGERS LAST			15. MOTHER'S MAIDEN NAME FIRST ELIZABETH MIDDLE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for item 18, Part I) PART I. DEATH WAS CAUSED BY					
No			Atwell			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			214-12-0971 Marion Nieman			ADDRESS			IMMEDIATE CAUSE (o)  Dementia					
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b) Dementia			DUE TO, OR AS A CONSEQUENCE OF (c)			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)										Depression										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE DEGREE										22c. DATE SIGNED 2/19/85										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CYRIL J. LACKO										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 2/19/85										
23c. NAME OF CEMETERY OR CREMATORIAL Quaker Cemetery										23d. LOCATION Towson, Md.										
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home										25a. ADDRESS 1a Ridgeley Ct.										
										25b. DATE REC'D. BY REGISTRAR FEB 20 1985										
										25c. REGISTRAR'S SIGNATURE Julie Davidson-Kendall										



4503452

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
	JOHN L. NIEMAN					Feb. 12, 1985	AM	4:05		M	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		7. UNDER 24 HRS		
MALE	WHITE		MONTH DAY YEAR			95	MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	YRS.				
SHADY SIDE MD.		U.S.A.			ANNE ARUNDEL CO.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	MD.				12b. KIND OF BUSINESS OR INDUSTRY	
CROFTON, MD.		CROFTON CONVALESCENT CARE			WATERMAN					SELF EMP.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	1487 NIEMAN DR. 20764					
MD.	A.A.CO.	SHADY SIDE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
14. FATHER'S NAME	FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME								
	JOHN DUDLEY NIEMAN		LAVANIA								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			ADDRESS					
NO			214-12-0971			Elizabeth Nieman same as 13 e.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DEHYDRATION</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROBABLE</u> <u>LUNG CARCINOMA</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/28/85</u> , 19 <u>85</u> , to <u>2/12/85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/11/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										22c. DATE SIGNED <u>2/12/85</u>	
21g. SIGNATURE <u>Cyril J. Lacko</u>		21h. DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CYRIL J. LACKO</u>		22e. ADDRESS <u>1438 Defense Highway, Gambrills, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/14/85		23c. NAME OF CEMETERY OR CREMATORIAL Quaker Cemetery			23d. LOCATION CITY OR TOWN Galesville, Md.		COUNTY STATE		
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home		ADDRESS Ridgely Ave Ann. Md. 21401			25a. DATE REC'D. BY REGISTRAR FEB 14 1985			25b. REGISTRAR'S SIGNATURE <u>Jeanne Davidson-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
REMAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the attending physician. Then please remove carbon papers. Page 2 should be filed within 72 hours of death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician. Then please remove carbon papers. Page 2 should be detached for use as the burial/transit permit. Then please file carbon paper copy with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
NOTE: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

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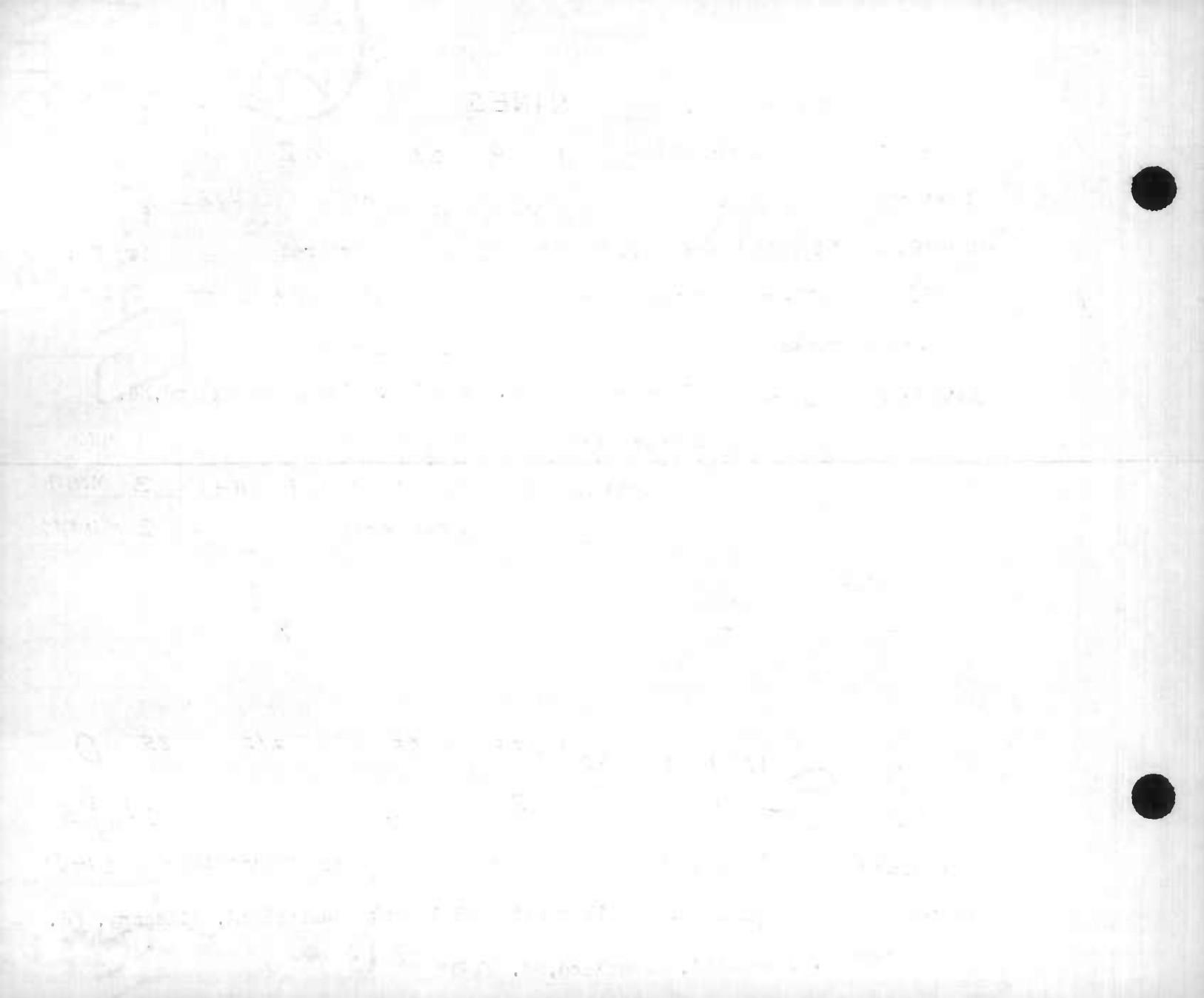
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please return carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked as item 18, then any injury, or other traumatic event, the medical examiner shall be notified of it.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85	03453		
										REG. NO.			
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
			THELMA B. NINES						2 2 85			1045 PM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR # UNDER 24 HRS	
Female			CAUCASIAN			1 9 23			62			MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.	
Kentucky			USA						ANNE ARUNDEL CO.			MD.	
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			CROWNsville, MD. 21032			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
ANNAPOLIS, MD			1029 PARK RD., BOX 237						Retired			Tire Co.	
13a. STATE MD.			13c. CITY OR TOWN Allegany			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 17 HUMBIRD ST. 21502				
14. FATHER'S NAME FIRST MIDDLE LAST			James Brooks			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			Lona Lawson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
UNKNOWN			No -			218-24-8192			Mr. Robert D. Nines, Cumberland, Md.			1 MIN.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST													
DUE TO, OR AS A CONSEQUENCE OF (b) CANCER OF THE STOMACH WITH: 3 MONTHS													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) LIVER METASTASIS 2 MONTHS													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a NONE													
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/22/85, to 2/2/85, that (I) (we) last saw the deceased alive on 1/22/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.													
22b. SIGNATURE Robert Scott Eden			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 2/6/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT SCOTT EDEN			22e. ADDRESS 703 GIDDINGS AVE, ANNAPOLIS, MD. 21401										
23a. BURIAL, CREMATION, REMOVAL AS PREFERRED Burial			23b. DATE 2-6-1985			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park			23d. LOCATION CITY OR TOWN Cumberland, Allegany, Md. COUNTY STATE				
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502			ADDRESS			25a. DATE RECEIVED BY FUNERAL DIRECTOR FEB 13 1985							
G													

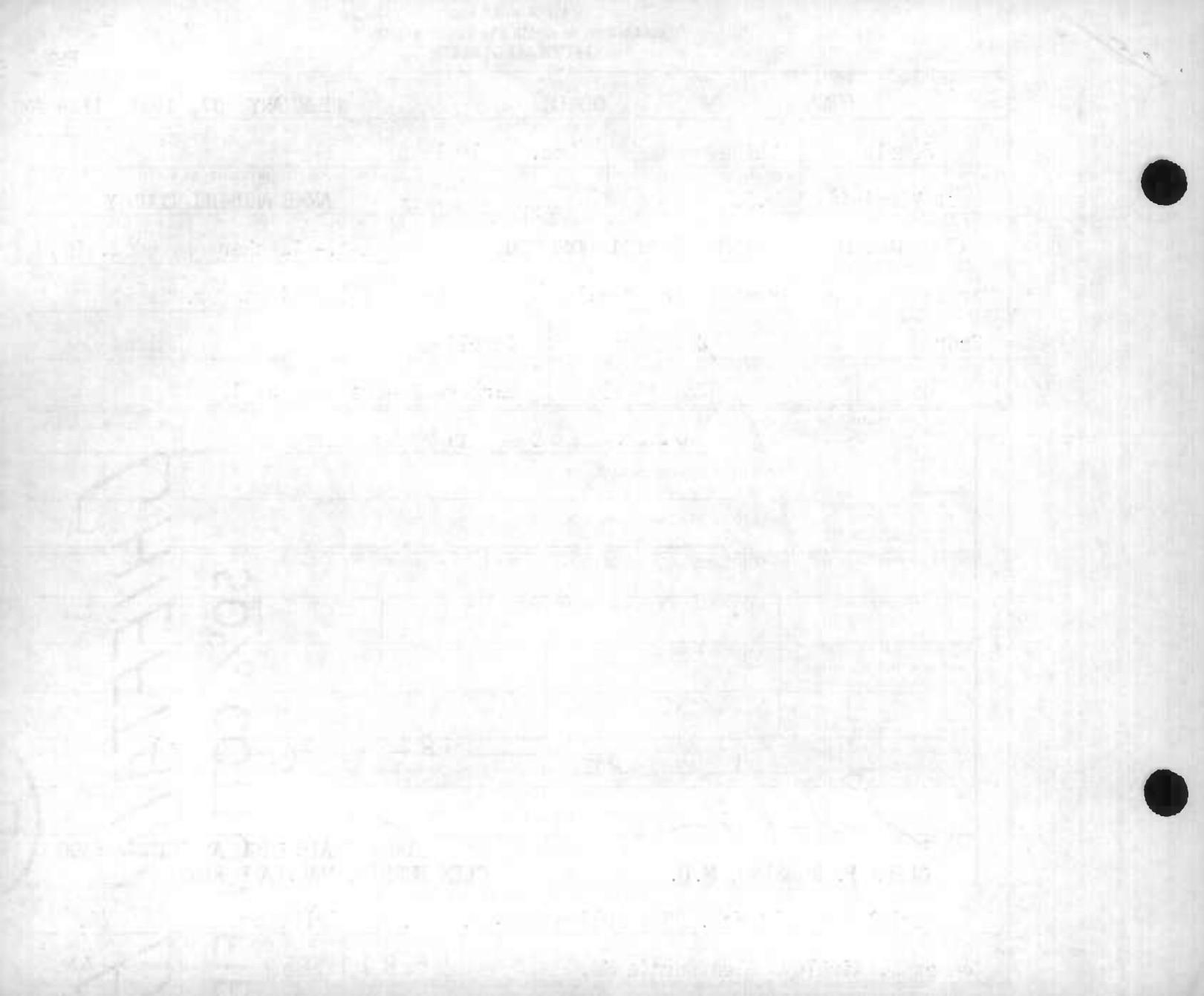


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8503454			
										REG. NO. EST			
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			EDNA M O'BRIEN						FEBRUARY 07, 1985			1129 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Dec. 10, 1900			84			MONTHS DAYS		HOURS MIN.	
YRS													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
West Virginia		U.S.A.					ANNE ARUNDEL COUNTY						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Ret.- Teacher			Education						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		Anne Arundel		Glen Burnie		NO		1330 Whitman Dr. 21061					
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME									
George				Caroline									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
no				234-36-7146		Barbara Bowers same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY P.M. HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK, NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 19 82 to 21 85, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Glenn Robbins</u> DEGREE M.D.										22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENN F. ROBBINS, M.D.										22e. ADDRESS 1404 CRAIN HIGHWAY SOUTH, #300 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		11 Feb. 85		Arlington Nat. Cem.			Arlington		VA.				
24. FUNERAL DIRECTOR NAME James S. Kirkley Glen Burnie MD.										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
										FEB 11 1985		<u>John Pendell</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical certification must be completed and must be included at time of filing.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 85 03455							
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST Hilma MIDDLE K.		LAST Ohman		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
		<i>Hilma K. OHMAN</i>								<i>2/10/85</i>		2	10	85	<i>6 55 M</i>		
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS			
<i>F emale</i>		<i>White</i>		MONTH <i>5</i> DAY <i>16</i> YEAR <i>1885</i>				99				MONTHS		DAYS			
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.					
<i>Sweden</i>		<i>U.S.A.</i>						<i>Anne Arundel County</i>									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
<i>Glen Burnie</i>		<i>North Arundel Convalescent Center</i>				<i>Housewife</i>				<i>Home Maker</i>							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE									
<i>Maryland</i>		<i>=====</i>		<i>Baltimore</i>				<i>3515 Horton Avenue 21225</i>									
14. FATHER'S NAME		FIRST Karl		MIDDLE		LAST Osman		15. MOTHER'S MAIDEN NAME				LAST					
								<i>Kristine</i>				<i>Roestrom</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN)		(YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
<i>No</i>				<i>212-74-8835</i>		<i>Edith Morris</i>		<i>Same as 13e</i>									
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>																	
DUE TO, OR AS A CONSEQUENCE OF { (b) <i>ASHD with atrial fibrillation,</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Possible mitral stenosis,</i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Venous stasis, both legs, with small ulcer, left leg.</i>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
<i>N/A</i>		<i>N/A</i>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)		21d. LOCATION				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)							
				<i>19</i>		<i>N/A</i>								<i>N/A</i>			
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21g. LOCATION		21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21i. LOCATION				21j. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 31</i> , 19 <i>84</i> , to <i>Feb. 10</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED							
<i>Benjamin A. Guzman MD</i>										<i>Feb. 10, 1985</i>							
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED					
<i>BENJAMIN A. de GUZMAN</i>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION		23e. ADDRESS							
Burial		<i>2/13/85</i>		<i>Meadowridge Mem Park</i>				<i>Balto</i>		<i>325, HOSPITAL DRIVE GLEN BURNIE, Md. 21061</i>							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
<i>George J. Goncze 4001 Ritchie Hwy Balto Md</i>		<i>FEB 13 1985</i>				<i>Julia Davidson-Pendall</i>											



BP

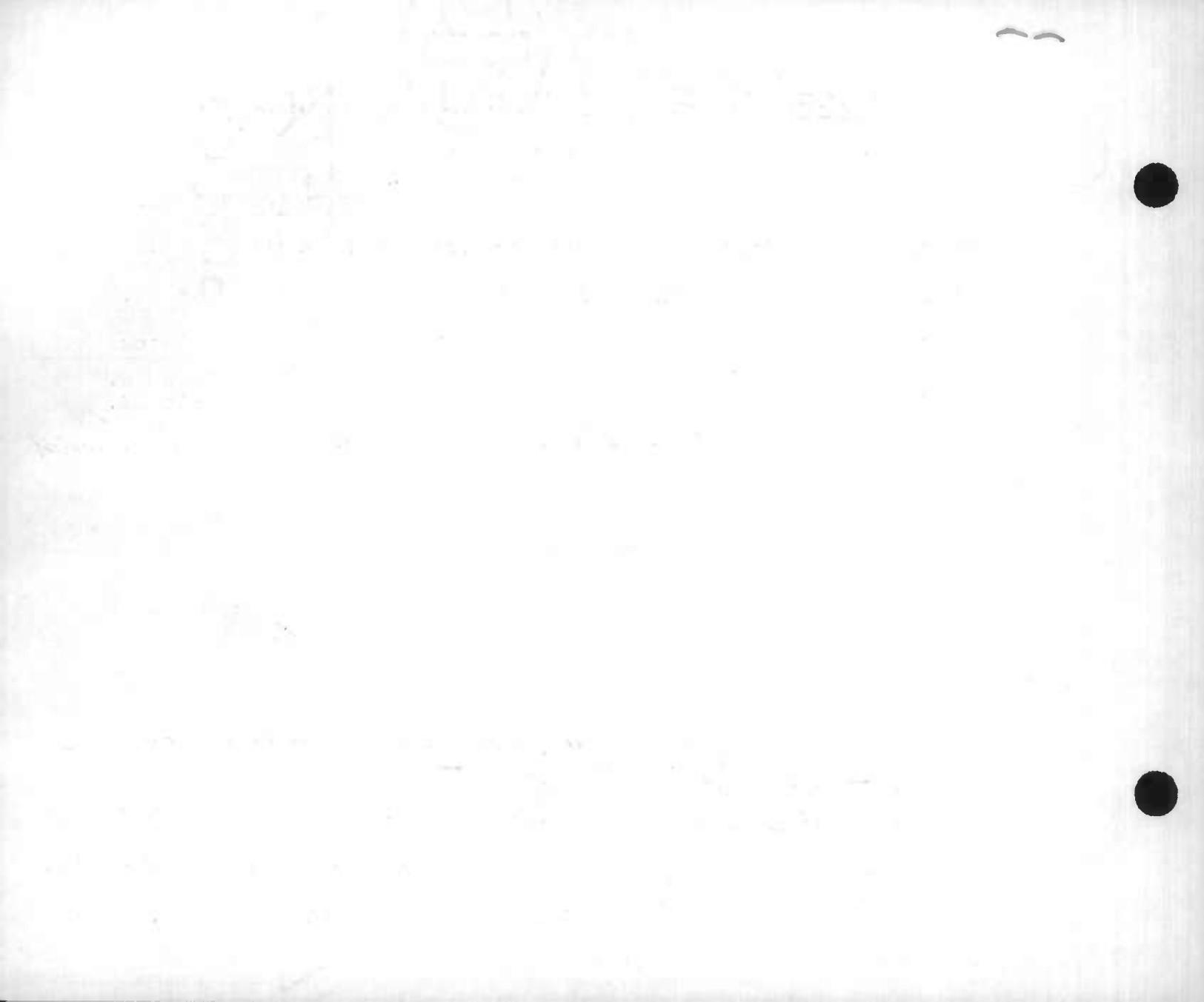
DHMH - 16 50M 4/83  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8503456

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME <b>Daisy E. O'NEILL</b>				2a. DATE OF DEATH <b>February 14, 1985</b>	MONTH YEAR	DAY	YEAR	2b. HOUR <b>7:59 AM</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>	5. DATE OF BIRTH <b>1-28-1893</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b>	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co. MD.</b>				
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Annapolis Convalescent Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Household</b>		
13a. STATE <b>Md.</b>		13b. COUNTY <b>AACo.</b>	13c. CITY OR TOWN <b>Annapolis</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>701 Glennwood St. 21401</b>			
14. FATHER'S NAME <b>Lee</b>		MIDDLE <b>Perry</b>	LAST <b>Slydelphia</b>	15. MOTHER'S MAIDEN NAME <b>Sheckells</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-74-0746</b>		17. INFORMANT <b>Doris L. O'Neill</b>		ADDRESS <b>12 Willow Rd. Annapolis Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable renal failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>4/25/69</b> to <b>2/14/85</b> , that (I) <input type="checkbox"/> last saw the deceased alive on <b>2/13/85</b> , and that in my <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.								
22b. SIGNATURE <b>R.I. Hochman, MD</b>		22c. ATTENDING PHYSICIAN <b>X</b> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <b>2/14/85</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-17-85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Zion</b>	23d. LOCATION CITY OR TOWN <b>Lothian AACo. md.</b>				
24 FUNERAL DIRECTOR NAME <b>Hardesty Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 15 1985</b>	25b. REGISTRAR'S SIGNATURE <b>Gillian Davidson-Randall</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	REG. NO.
				JOHN		PARKER	85 03451
3. SEX	M	4. RACE	BLACK	5. DATE OF BIRTH	MONTH 2 DAY 22 YEAR 25	6. AGE (IN YEARS LAST BIRTHDAY)	59 YRS.
7a. BIRTHPLACE STATE OR FOREIGN	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH	ANNE ARUNDEL COUNTY MD.
10. CITY OR TOWN OF DEATH	Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Anne Arundel Gen Hosp	12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE	MARYLAND	13b. COUNTY	A.A.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	4842 Solomons Island Rd.	20776
14. FATHER'S NAME	FIRST THOMAS	MIDDLE	LAST PARKER	15. MOTHER'S MAIDEN NAME	FIRST FLORENCE	MIDDLE	LAST FREELAND
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (OR UNKNOWN)	NO	16b. SOCIAL SECURITY NO.	218-12-9360	17. INFORMANT	Harwood, Maryland 20776		
PART 1 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)				ELEANOR PARKER 4842 Solomons Island Rd.			
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Acute congestive heart failure minutes			
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic congestive heart failure years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Disease years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
Arthritis							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	No injury				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 22/1/85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I will) (did) (did not) view the body after death.				19 1970 2/2 1985	19 1970 2/2 1985	19 1970 2/2 1985	19 1970 2/2 1985
22b. SIGNATURE CHARLES WIRTH MD				DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>
22c. ADDRESS Charles Wirth				22d. ADDRESS Lothian Md 20711	22e. ADDRESS Lothian Md 20711	22f. ADDRESS Lothian Md 20711	22g. ADDRESS Lothian Md 20711
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 2-5-1985	23c. NAME OF CEMETERY OR CREMATORIAL ADAMS CHURCH CEME.	23d. LOCATION CITY OR TOWN Lothian	23e. COUNTY A.A.	23f. STATE Maryland		
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.	ADDRESS 24401	25a. DATE REC'D. BY REGISTRAR FFB 7 1985	25b. REGISTRAR'S SIGNATURE Julia Wirth				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of issue with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

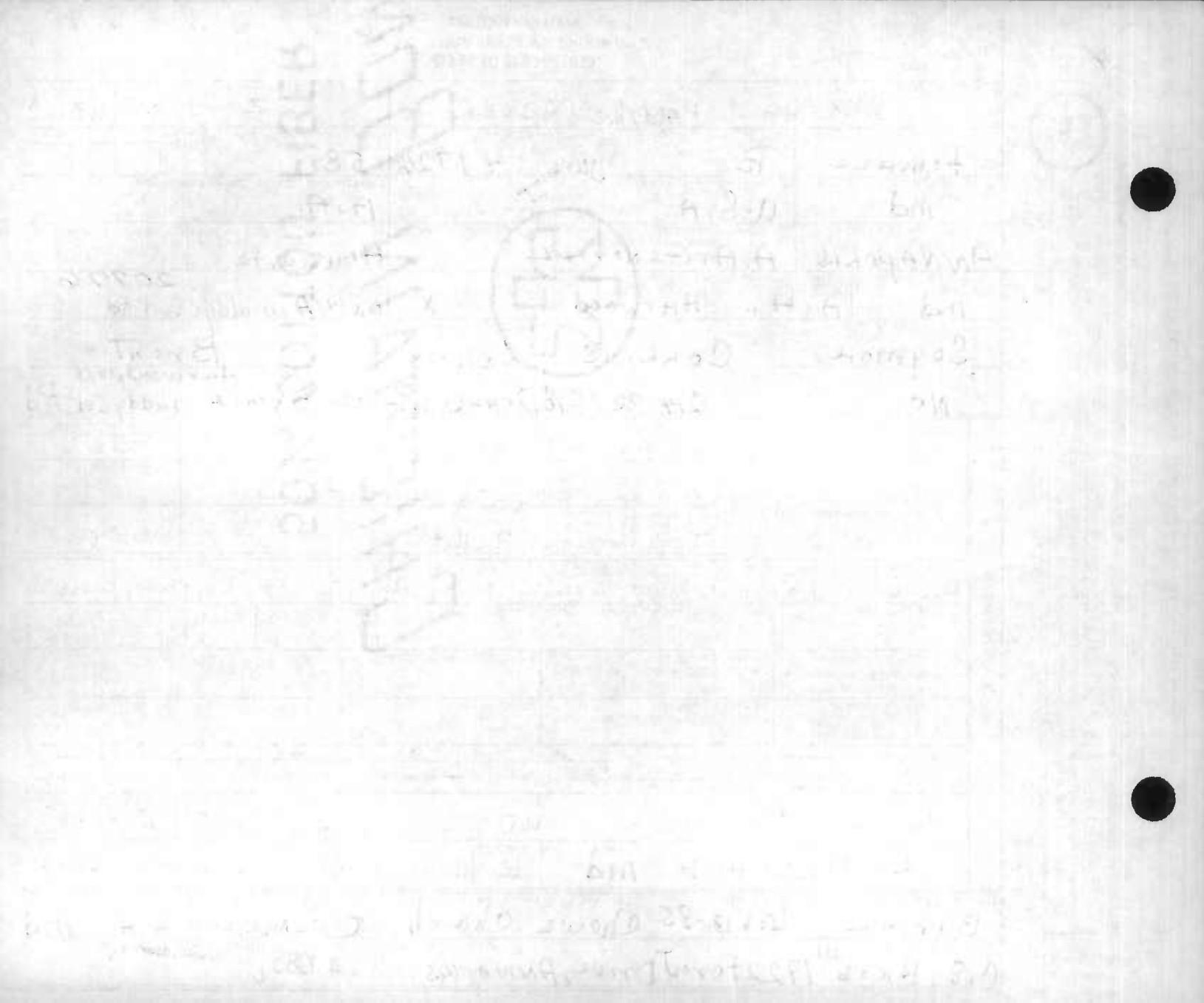
## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8503458		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Lois</i>	MIDDLE <i>L.</i>	LAST <i>PARKER</i>	2a. DATE OF DEATH			MONTH <i>2</i>	DAY <i>21</i>	YEAR <i>1985</i>	2b. HOUR <i>M</i>
3. SEX <i>FEMALE</i>			4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH <i>10</i> DAY <i>01</i> YEAR <i>19</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i> YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i>			MD	
10. CITY OR TOWN OF DEATH <i>Annapolis, Md.</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel Gen. Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Seamstress</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>31035</i>				
13a. STATE <i>Maryland</i>			13b. COUNTY		13c. CITY OR TOWN <i>Davidsonville</i>			13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>631 Schaffer Lane</i>	
14. FATHER'S NAME FIRST <i>John</i>			MIDDLE <i>Thomas</i>	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>Rhoda</i>			MIDDLE	LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>236 58 0202</i>		17. INFORMANT ADDRESS <i>Richard Parker-son-631 Schaffer Lane, Davidsonville, Maryland</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death										22b. DATE SIGNED <i>2/27/85</i>		
22c. SIGNATURE <i>H. Baker</i>										DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
23a. BURIAL, CREMATION REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Feb. 27 1985</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>John Stewart III Funeral Home-4001 Benning Road</i>			23d. LOCATION CITY OR TOWN <i>Princeton, West Virginia</i>				
24. FUNERAL DIRECTOR NAME <i>John Stewart III</i>			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Feb 28 1985 Julie Dawson-Parker</i>									

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XOC





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and retained by the hospital or attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 4 may be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked all items 18 through 23 must be checked.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												03-60	
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	REG. NO.	EST					
LEAH TEXA PARSONS													
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>June 10, 1907</i>		20. DATE OF DEATH <i>FEBRUARY 28, 1985</i>		MONTH	DAY	YEAR	21. HOUR <i>11:45 A.M.</i>		
7a. BIRTHPLACE <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i>		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.			
9. BALTIMORE CITY OR COUNTY OF DEATH <i>ANNE ARUNDEL COUNTY MD.</i>													
10. CITY OR TOWN OF DEATH <i>GLEN BURNIE</i>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>NORTH ARUNDEL HOSPITAL</i>				12a. USUAL OCCUPATION <i>Retired Clerk - Hilt's Store</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Hilt's Store</i>			
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE <i>616 Opel Road Glen Burnie, Md. 21061</i>			
14. FATHER'S NAME <i>(unknown)</i>				MIDDLE		LAST <i>Davis</i>		15. MOTHER'S MAIDEN NAME <i>Alice</i>		MIDDLE <i>Matilda</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>213-26-5726</i>		17. INFORMANT <i>Mr. Randall Parsons (son)</i>		ADDRESS <i>Glen Burnie, Md. 21061</i>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 1a)				<i>Cerebral Vascular Attack</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 months</i>	
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart Failure</i>								12 months	
				DUE TO, OR AS A CONSEQUENCE OF (c) <i>Recurrent Trigeminal Neuralgia</i>								11 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>2/28/85</i> to <i>2/28/85</i> , 1985, to <i>2/28/85</i> , 1985, that (II) the last saw the deceased alive on <i>2/28/85</i> , 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (not) view the body after death.													
22b. SIGNATURE <i>Elliott Gorbaty, M.D.</i>			22c. DEGREE <input checked="" type="checkbox"/> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS <i>7845 OAKWOOD ROAD #203</i>			22e. DATE SIGNED <i>2/28/85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ELLIOTT GORBATY, M.D.</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>March 4, 1985</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Meadowridge Mem Park Dorsey</i>			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME <i>Ac Supply Funeral Home of Pasadena Mountain &amp; Pickwick Kas. Pasadena, Md. 21122</i>									25. DATE REC'D. BY REGISTRAR <i>MAR 1 1985</i>		26. REGISTRAR'S SIGNATURE <i>W. Henderson-Kendall</i>		

20 NOV 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "No," attach any injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 8503461		
1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>HELEN EYE PAYNE</b>	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR <b>2 12 85</b>	2b. HOUR <b>1017 AM</b>	
3. SEX <b>F</b>		4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 27 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR <b>66</b> MONTHS DAYS HOURS MIN. YRS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>HOT SPRINGS VA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b>		
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARIAL</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>ANNE ARUNDEL</b>	13c. CITY OR TOWN <b>ANNAPOLIS</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>871 COMMUNITY, ANNAPOLIS 21401</b>		
14. FATHER'S NAME FIRST <b>GROVER</b>		MIDDLE <b>C</b>	LAST <b>EYE</b>	15. MOTHER'S MAIDEN NAME FIRST <b>LENA</b>		MIDDLE <b>HORN</b>	LAST <b>EYE</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>224-24-8075</b>		17. INFORMANT <b>MARTHA CHAMPION</b>		ADDRESS		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>TRIMED</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADENOCARCINOMA LUNG</b> APPROX. 1 YR</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) _____</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
<p>22a. I certify that (I) (this hospital) attended the deceased from <b>2-12 1985</b> to <b>2-12 1985</b>, that (I) (we) last saw the deceased alive on <b>2-12 1985</b>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>								
22b. SIGNATURE <b>John D. Jackson MD</b>		22c. DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <b>2-12-85</b>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN D. JACKSON MD</b>		22f. ADDRESS <b>1419 FOREST DR., ANNAPOLIS, MD 21403</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>2/15/85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Scotsville Cem.</b>		23d. LOCATION CITY OR TOWN <b>Scotsville, Va.</b>		COUNTY	STATE
24. FUNERAL DIRECTOR NAME <b>David Kappeler</b>		24b. ADDRESS <b>Conservative Funeral Home Inc., P.O. Box, Va.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 20 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Jean Davidson-Randall</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

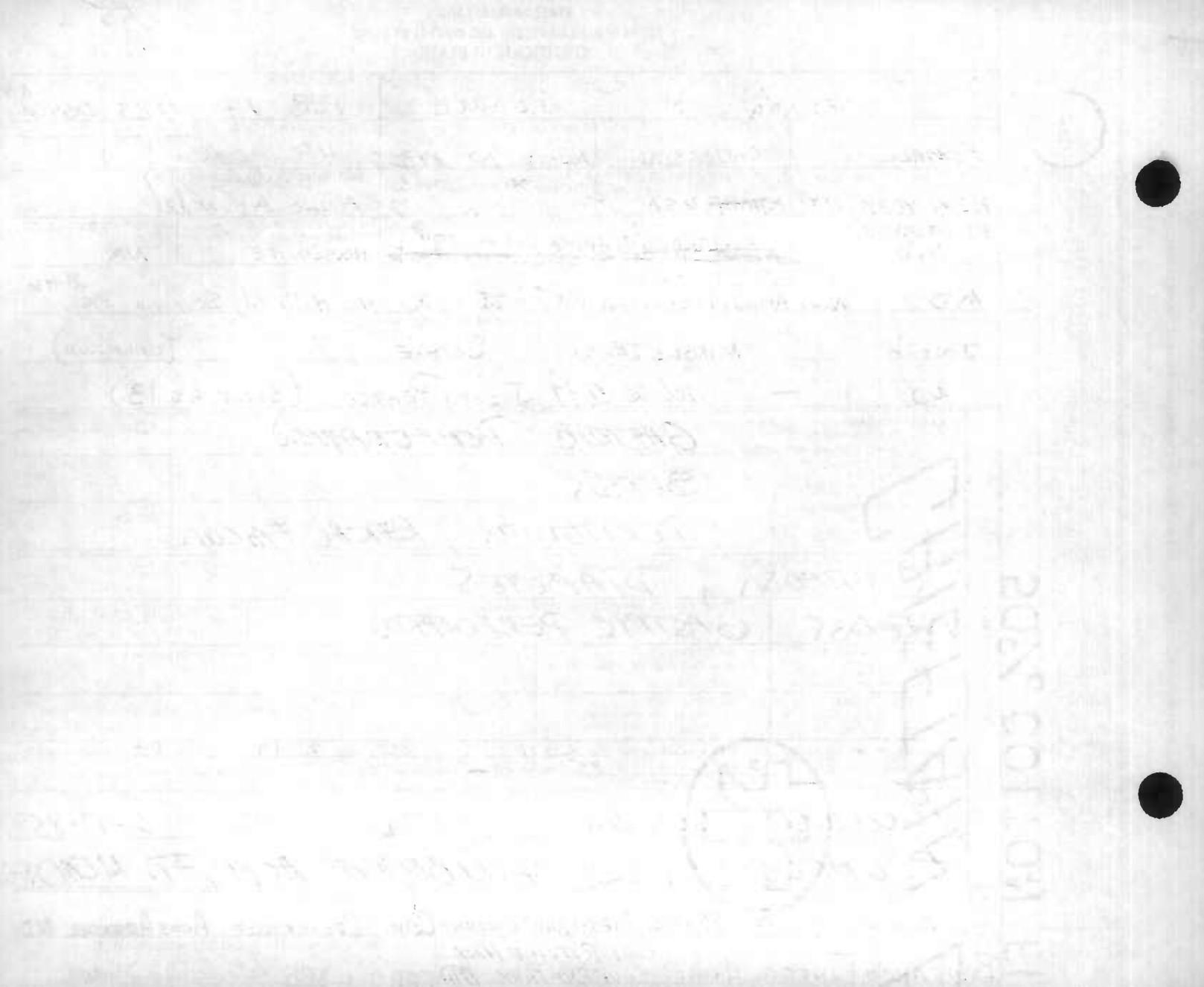
IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 03462  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
BARBARA H. PEARCE						FEB	17	1985	AM 0500hr				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
FEMALE		CAUCASIAN		MONTH	DAY	YEAR	48		IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.				
NEW YORK, NY		KIMBR USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ANNE ARUNDEL							
10. CITY OR TOWN OF DEATH MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
PT MEADE		KIMBROUGH ALMS COMM. HOSP ANN ARUNDEL SEVERNA PARK		HOUSEWIFE			NA						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						21146							
13a. STATE MD		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severna Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 45 Holly Rd, Severna Park					
14. FATHER'S NAME FIRST Joseph		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST SOPHIE		LAST (UNKNOWN)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. —		16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		17. INFORMANT JOSEPH PEARCE		ADDRESS (SAME AS 13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c) PERITONITIS, RENAL FAILURE													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CIRRHOsis & DIABETES													
19a. DATE OF OPERATION 15 FEB 85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GASTRIC PERFORATION				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (s) (this hospital) attended the deceased from 8-14, 19 85, to 2-17, 19 85, that (I) (we) last saw the deceased alive on 2-16, 19 85, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.													
22b. SIGNATURE EDUARDO CUISON						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) EDUARDO CUISON						22d. DATE SIGNED 2-17-85							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL						23b. DATE FEB-20, 1985		23c. NAME OF CEMETERY OR CREMATORIAL MARYLAND VETERANS Cem.		23d. LOCATION CROWNSVILLE		COUNTY ANNE ARUNDEL MD.	
24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME						501 RITCHIE Hwy.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandell			
SEVERNA PARK, MD						FEB 21 1985							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 21 is marked or Item 24 is marked or Item 25 is marked or Item 26 is marked or Item 27 is marked or Item 28 is marked or Item 29 is marked or Item 30 is marked or Item 31 is marked or Item 32 is marked or Item 33 is marked or Item 34 is marked or Item 35 is marked or Item 36 is marked or Item 37 is marked or Item 38 is marked or Item 39 is marked or Item 40 is marked or Item 41 is marked or Item 42 is marked or Item 43 is marked or Item 44 is marked or Item 45 is marked or Item 46 is marked or Item 47 is marked or Item 48 is marked or Item 49 is marked or Item 50 is marked or Item 51 is marked or Item 52 is marked or Item 53 is marked or Item 54 is marked or Item 55 is marked or Item 56 is marked or Item 57 is marked or Item 58 is marked or Item 59 is marked or Item 60 is marked or Item 61 is marked or Item 62 is marked or Item 63 is marked or Item 64 is marked or Item 65 is marked or Item 66 is marked or Item 67 is marked or Item 68 is marked or Item 69 is marked or Item 70 is marked or Item 71 is marked or Item 72 is marked or Item 73 is marked or Item 74 is marked or Item 75 is marked or Item 76 is marked or Item 77 is marked or Item 78 is marked or Item 79 is marked or Item 80 is marked or Item 81 is marked or Item 82 is marked or Item 83 is marked or Item 84 is marked or Item 85 is marked or Item 86 is marked or Item 87 is marked or Item 88 is marked or Item 89 is marked or Item 90 is marked or Item 91 is marked or Item 92 is marked or Item 93 is marked or Item 94 is marked or Item 95 is marked or Item 96 is marked or Item 97 is marked or Item 98 is marked or Item 99 is marked or Item 100 is marked or Item 101 is marked or Item 102 is marked or Item 103 is marked or Item 104 is marked or Item 105 is marked or Item 106 is marked or Item 107 is marked or Item 108 is marked or Item 109 is marked or Item 110 is marked or Item 111 is marked or Item 112 is marked or Item 113 is marked or Item 114 is marked or Item 115 is marked or Item 116 is marked or Item 117 is marked or Item 118 is marked or Item 119 is marked or Item 120 is marked or Item 121 is marked or Item 122 is marked or Item 123 is marked or Item 124 is marked or Item 125 is marked or Item 126 is marked or Item 127 is marked or Item 128 is marked or Item 129 is marked or Item 130 is marked or Item 131 is marked or Item 132 is marked or Item 133 is marked or Item 134 is marked or Item 135 is marked or Item 136 is marked or Item 137 is marked or Item 138 is marked or Item 139 is marked or Item 140 is marked or Item 141 is marked or Item 142 is marked or Item 143 is marked or Item 144 is marked or Item 145 is marked or Item 146 is marked or Item 147 is marked or Item 148 is marked or Item 149 is marked or Item 150 is marked or Item 151 is marked or Item 152 is marked or Item 153 is marked or Item 154 is marked or Item 155 is marked or Item 156 is marked or Item 157 is marked or Item 158 is marked or Item 159 is marked or Item 160 is marked or Item 161 is marked or Item 162 is marked or Item 163 is marked or Item 164 is marked or Item 165 is marked or Item 166 is marked or Item 167 is marked or Item 168 is marked or Item 169 is marked or Item 170 is marked or Item 171 is marked or Item 172 is marked or Item 173 is marked or Item 174 is marked or Item 175 is marked or Item 176 is marked or Item 177 is marked or Item 178 is marked or Item 179 is marked or Item 180 is marked or Item 181 is marked or Item 182 is marked or Item 183 is marked or Item 184 is marked or Item 185 is marked or Item 186 is marked or Item 187 is marked or Item 188 is marked or Item 189 is marked or Item 190 is marked or Item 191 is marked or Item 192 is marked or Item 193 is marked or Item 194 is marked or Item 195 is marked or Item 196 is marked or Item 197 is marked or Item 198 is marked or Item 199 is marked or Item 200 is marked or Item 201 is marked or Item 202 is marked or Item 203 is marked or Item 204 is marked or Item 205 is marked or Item 206 is marked or Item 207 is marked or Item 208 is marked or Item 209 is marked or Item 210 is marked or Item 211 is marked or Item 212 is marked or Item 213 is marked or Item 214 is marked or Item 215 is marked or Item 216 is marked or Item 217 is marked or Item 218 is marked or Item 219 is marked or Item 220 is marked or Item 221 is marked or Item 222 is marked or Item 223 is marked or Item 224 is marked or Item 225 is marked or Item 226 is marked or Item 227 is marked or Item 228 is marked or Item 229 is marked or Item 230 is marked or Item 231 is marked or Item 232 is marked or Item 233 is marked or Item 234 is marked or Item 235 is marked or Item 236 is marked or Item 237 is marked or Item 238 is marked or Item 239 is marked or Item 240 is marked or Item 241 is marked or Item 242 is marked or Item 243 is marked or Item 244 is marked or Item 245 is marked or Item 246 is marked or Item 247 is marked or Item 248 is marked or Item 249 is marked or Item 250 is marked or Item 251 is marked or Item 252 is marked or Item 253 is marked or Item 254 is marked or Item 255 is marked or Item 256 is marked or Item 257 is marked or Item 258 is marked or Item 259 is marked or Item 260 is marked or Item 261 is marked or Item 262 is marked or Item 263 is marked or Item 264 is marked or Item 265 is marked or Item 266 is marked or Item 267 is marked or Item 268 is marked or Item 269 is marked or Item 270 is marked or Item 271 is marked or Item 272 is marked or Item 273 is marked or Item 274 is marked or Item 275 is marked or Item 276 is marked or Item 277 is marked or Item 278 is marked or Item 279 is marked or Item 280 is marked or Item 281 is marked or Item 282 is marked or Item 283 is marked or Item 284 is marked or Item 285 is marked or Item 286 is marked or Item 287 is marked or Item 288 is marked or Item 289 is marked or Item 290 is marked or Item 291 is marked or Item 292 is marked or Item 293 is marked or Item 294 is marked or Item 295 is marked or Item 296 is marked or Item 297 is marked or Item 298 is marked or Item 299 is marked or Item 300 is marked or Item 301 is marked or Item 302 is marked or Item 303 is marked or Item 304 is marked or Item 305 is marked or Item 306 is marked or Item 307 is marked or Item 308 is marked or Item 309 is marked or Item 310 is marked or Item 311 is marked or Item 312 is marked or Item 313 is marked or Item 314 is marked or Item 315 is marked or Item 316 is marked or Item 317 is marked or Item 318 is marked or Item 319 is marked or Item 320 is marked or Item 321 is marked or Item 322 is marked or Item 323 is marked or Item 324 is marked or Item 325 is marked or Item 326 is marked or Item 327 is marked or Item 328 is marked or Item 329 is marked or Item 330 is marked or Item 331 is marked or Item 332 is marked or Item 333 is marked or Item 334 is marked or Item 335 is marked or Item 336 is marked or Item 337 is marked or Item 338 is marked or Item 339 is marked or Item 340 is marked or Item 341 is marked or Item 342 is marked or Item 343 is marked or Item 344 is marked or Item 345 is marked or Item 346 is marked or Item 347 is marked or Item 348 is marked or Item 349 is marked or Item 350 is marked or Item 351 is marked or Item 352 is marked or Item 353 is marked or Item 354 is marked or Item 355 is marked or Item 356 is marked or Item 357 is marked or Item 358 is marked or Item 359 is marked or Item 360 is marked or Item 361 is marked or Item 362 is marked or Item 363 is marked or Item 364 is marked or Item 365 is marked or Item 366 is marked or Item 367 is marked or Item 368 is marked or Item 369 is marked or Item 370 is marked or Item 371 is marked or Item 372 is marked or Item 373 is marked or Item 374 is marked or Item 375 is marked or Item 376 is marked or Item 377 is marked or Item 378 is marked or Item 379 is marked or Item 380 is marked or Item 381 is marked or Item 382 is marked or Item 383 is marked or Item 384 is marked or Item 385 is marked or Item 386 is marked or Item 387 is marked or Item 388 is marked or Item 389 is marked or Item 390 is marked or Item 391 is marked or Item 392 is marked or Item 393 is marked or Item 394 is marked or Item 395 is marked or Item 396 is marked or Item 397 is marked or Item 398 is marked or Item 399 is marked or Item 400 is marked or Item 401 is marked or Item 402 is marked or Item 403 is marked or Item 404 is marked or Item 405 is marked or Item 406 is marked or Item 407 is marked or Item 408 is marked or Item 409 is marked or Item 410 is marked or Item 411 is marked or Item 412 is marked or Item 413 is marked or Item 414 is marked or Item 415 is marked or Item 416 is marked or Item 417 is marked or Item 418 is marked or Item 419 is marked or Item 420 is marked or Item 421 is marked or Item 422 is marked or Item 423 is marked or Item 424 is marked or Item 425 is marked or Item 426 is marked or Item 427 is marked or Item 428 is marked or Item 429 is marked or Item 430 is marked or Item 431 is marked or Item 432 is marked or Item 433 is marked or Item 434 is marked or Item 435 is marked or Item 436 is marked or Item 437 is marked or Item 438 is marked or Item 439 is marked or Item 440 is marked or Item 441 is marked or Item 442 is marked or Item 443 is marked or Item 444 is marked or Item 445 is marked or Item 446 is marked or Item 447 is marked or Item 448 is marked or Item 449 is marked or Item 450 is marked or Item 451 is marked or Item 452 is marked or Item 453 is marked or Item 454 is marked or Item 455 is marked or Item 456 is marked or Item 457 is marked or Item 458 is marked or Item 459 is marked or Item 460 is marked or Item 461 is marked or Item 462 is marked or Item 463 is marked or Item 464 is marked or Item 465 is marked or Item 466 is marked or Item 467 is marked or Item 468 is marked or Item 469 is marked or Item 470 is marked or Item 471 is marked or Item 472 is marked or Item 473 is marked or Item 474 is marked or Item 475 is marked or Item 476 is marked or Item 477 is marked or Item 478 is marked or Item 479 is marked or Item 480 is marked or Item 481 is marked or Item 482 is marked or Item 483 is marked or Item 484 is marked or Item 485 is marked or Item 486 is marked or Item 487 is marked or Item 488 is marked or Item 489 is marked or Item 490 is marked or Item 491 is marked or Item 492 is marked or Item 493 is marked or Item 494 is marked or Item 495 is marked or Item 496 is marked or Item 497 is marked or Item 498 is marked or Item 499 is marked or Item 500 is marked or Item 501 is marked or Item 502 is marked or Item 503 is marked or Item 504 is marked or Item 505 is marked or Item 506 is marked or Item 507 is marked or Item 508 is marked or Item 509 is marked or Item 510 is marked or Item 511 is marked or Item 512 is marked or Item 513 is marked or Item 514 is marked or Item 515 is marked or Item 516 is marked or Item 517 is marked or Item 518 is marked or Item 519 is marked or Item 520 is marked or Item 521 is marked or Item 522 is marked or Item 523 is marked or Item 524 is marked or Item 525 is marked or Item 526 is marked or Item 527 is marked or Item 528 is marked or Item 529 is marked or Item 530 is marked or Item 531 is marked or Item 532 is marked or Item 533 is marked or Item 534 is marked or Item 535 is marked or Item 536 is marked or Item 537 is marked or Item 538 is marked or Item 539 is marked or Item 540 is marked or Item 541 is marked or Item 542 is marked or Item 543 is marked or Item 544 is marked or Item 545 is marked or Item 546 is marked or Item 547 is marked or Item 548 is marked or Item 549 is marked or Item 550 is marked or Item 551 is marked or Item 552 is marked or Item 553 is marked or Item 554 is marked or Item 555 is marked or Item 556 is marked or Item 557 is marked or Item 558 is marked or Item 559 is marked or Item 560 is marked or Item 561 is marked or Item 562 is marked or Item 563 is marked or Item 564 is marked or Item 565 is marked or Item 566 is marked or Item 567 is marked or Item 568 is marked or Item 569 is marked or Item 570 is marked or Item 571 is marked or Item 572 is marked or Item 573 is marked or Item 574 is marked or Item 575 is marked or Item 576 is marked or Item 577 is marked or Item 578 is marked or Item 579 is marked or Item 580 is marked or Item 581 is marked or Item 582 is marked or Item 583 is marked or Item 584 is marked or Item 585 is marked or Item 586 is marked or Item 587 is marked or Item 588 is marked or Item 589 is marked or Item 590 is marked or Item 591 is marked or Item 592 is marked or Item 593 is marked or Item 594 is marked or Item 595 is marked or Item 596 is marked or Item 597 is marked or Item 598 is marked or Item 599 is marked or Item 600 is marked or Item 601 is marked or Item 602 is marked or Item 603 is marked or Item 604 is marked or Item 605 is marked or Item 606 is marked or Item 607 is marked or Item 608 is marked or Item 609 is marked or Item 610 is marked or Item 611 is marked or Item 612 is marked or Item 613 is marked or Item 614 is marked or Item 615 is marked or Item 616 is marked or Item 617 is marked or Item 618 is marked or Item 619 is marked or Item 620 is marked or Item 621 is marked or Item 622 is marked or Item 623 is marked or Item 624 is marked or Item 625 is marked or Item 626 is marked or Item 627 is marked or Item 628 is marked or Item 629 is marked or Item 630 is marked or Item 631 is marked or Item 632 is marked or Item 633 is marked or Item 634 is marked or Item 635 is marked or Item 636 is marked or Item 637 is marked or Item 638 is marked or Item 639 is marked or Item 640 is marked or Item 641 is marked or Item 642 is marked or Item 643 is marked or Item 644 is marked or Item 645 is marked or Item 646 is marked or Item 647 is marked or Item 648 is marked or Item 649 is marked or Item 650 is marked or Item 651 is marked or Item 652 is marked or Item 653 is marked or Item 654 is marked or Item 655 is marked or Item 656 is marked or Item 657 is marked or Item 658 is marked or Item 659 is marked or Item 660 is marked or Item 661 is marked or Item 662 is marked or Item 663 is marked or Item 664 is marked or Item 665 is marked or Item 666 is marked or Item 667 is marked or Item 668 is marked or Item 669 is marked or Item 670 is marked or Item 671 is marked or Item 672 is marked or Item 673 is marked or Item 674 is marked or Item 675 is marked or Item 676 is marked or Item 677 is marked or Item 678 is marked or Item 679 is marked or Item 680 is marked or Item 681 is marked or Item 682 is marked or Item 683 is marked or Item 684 is marked or Item 685 is marked or Item 686 is marked or Item 687 is marked or Item 688 is marked or Item 689 is marked or Item 690 is marked or Item 691 is marked or Item 692 is marked or Item 693 is marked or Item 694 is marked or Item 695 is marked or Item 696 is marked or Item 697 is marked or Item 698 is marked or Item 699 is marked or Item 700 is marked or Item 701 is marked or Item 702 is marked or Item 703 is marked or Item 704 is marked or Item 705 is marked or Item 706 is marked or Item 707 is marked or Item 708 is marked or Item 709 is marked or Item 710 is marked or Item 711 is marked or Item 712 is marked or Item 713 is marked or Item 714 is marked or Item 715 is marked or Item 716 is marked or Item 717 is marked or Item 718 is marked or Item 719 is marked or Item 720 is marked or Item 721 is marked or Item 722 is marked or Item 723 is marked or Item 724 is marked or Item 725 is marked or Item 726 is marked or Item 727 is marked or Item 728 is marked or Item 729 is marked or Item 730 is marked or Item 731 is marked or Item 732 is marked or Item 733 is marked or Item 734 is marked or Item 735 is marked or Item 736 is marked or Item 737 is marked or Item 738 is marked or Item 739 is marked or Item 740 is marked or Item 741 is marked or Item 742 is marked or Item 743 is marked or Item 744 is marked or Item 745 is marked or Item 746 is marked or Item 747 is marked or Item 748 is marked or Item 749 is marked or Item 750 is marked or Item 751 is marked or Item 752 is marked or Item 753 is marked or Item 754 is marked or Item 755 is marked or Item 756 is marked or Item 757 is marked or Item 758 is marked or Item 759 is marked or Item 760 is marked or Item 761 is marked or Item 762 is marked or Item 763 is marked or Item 764 is marked or Item 765 is marked or Item 766 is marked or Item 767 is marked or Item 768 is marked or Item 769 is marked or Item 770 is marked or Item 771 is marked or Item 772 is marked or Item 773 is marked or Item 774 is marked or Item 775 is marked or Item 776 is marked or Item 777 is marked or Item 778 is marked or Item 779 is marked or Item 780 is marked or Item 781 is marked or Item 782 is marked or Item 783 is marked or Item 784 is marked or Item 785 is marked or Item 786 is marked or Item 787 is marked or Item 788 is marked or Item 789 is marked or Item 790 is marked or Item 791 is marked or Item 792 is marked or Item 793 is marked or Item 794 is marked or Item 795 is marked or Item 796 is marked or Item 797 is marked or Item 798 is marked or Item 799 is marked or Item 800 is marked or Item 801 is marked or Item 802 is marked or Item 803 is marked or Item 804 is marked or Item 805 is marked or Item 806 is marked or Item 807 is marked or Item 808 is marked or Item 809 is marked or Item 810 is marked or Item 811 is marked or Item 812 is marked or Item 813 is marked or Item 814 is marked or Item 815 is marked or Item 816 is marked or Item 817 is marked or Item 818 is marked or Item 819 is marked or Item 820 is marked or Item 821 is marked or Item 822 is marked or Item 823 is marked or Item 824 is marked or Item 825 is marked or Item 826 is marked or Item 827 is marked or Item 828 is marked or Item 829 is marked or Item 830 is marked or Item 831 is marked or Item 832 is marked or Item 833 is marked or Item 834 is marked or Item 835 is marked or Item 836 is marked or Item 837 is marked or Item 838 is marked or Item 839 is marked or Item 840 is marked or Item 841 is marked or Item 842 is marked or Item 843 is marked or Item 844 is marked or Item 845 is marked or Item 846 is marked or Item 847 is marked or Item 848 is marked or Item 849 is marked or Item 850 is marked or Item 851 is marked or Item 852 is marked or Item 853 is marked or Item 854 is marked or Item 855 is marked or Item 856 is marked or Item 857 is marked or Item 858 is marked or Item 859 is marked or Item 860 is marked or Item 861 is marked or Item 862 is marked or Item 863 is marked or Item 864 is marked or Item 865 is marked or Item 866 is marked or Item 867 is marked or Item 868 is marked or Item 869 is marked or Item 870 is marked or Item 871 is marked or Item 872 is marked or Item 873 is marked or Item 874 is marked or Item 875 is marked or Item 876 is marked or Item 877 is marked or Item 878 is marked or Item 879 is marked or Item 880 is marked or Item 881 is marked or Item 882 is marked or Item 883 is marked or Item 884 is marked or Item 885 is marked or Item 886 is marked or Item 887 is marked or Item 888 is marked or Item 889 is marked or Item 890 is marked or Item 891 is marked or Item 892 is marked or Item 893 is marked or Item 894 is marked or Item 895 is marked or Item 896 is marked or Item 897 is marked or Item 898 is marked or Item 899 is marked or Item 900 is marked or Item 901 is marked or Item 902 is marked or Item 903 is marked or Item 904 is marked or Item 905 is marked or Item 906 is marked or Item 907 is marked or Item 908 is marked or Item 909 is marked or Item 910 is marked or Item 911 is marked or Item 912 is marked or Item 913 is marked or Item 914 is marked or Item 915 is marked or Item 916 is marked or Item 917 is marked or Item 918 is marked or Item 919 is marked or Item 920 is marked or Item 921 is marked or Item 922 is marked or Item 923 is marked or Item 924 is marked or Item 925 is marked or Item 926 is marked or Item 927 is marked or Item 928 is marked or Item 929 is marked or Item 930 is marked or Item 931 is marked or Item 932 is marked or Item 933 is marked or Item 934 is marked or Item 935 is marked or Item 936 is marked or Item 937 is marked or Item 938 is marked or Item 939 is marked or Item 940 is marked or Item 941 is marked or Item 942 is marked or Item 943 is marked or Item 944 is marked or Item 945 is marked or Item 946 is marked or Item 947 is marked or Item 948 is marked or Item 949 is marked or Item 950 is marked or Item 951 is marked or Item 952 is marked or Item 953 is marked or Item 954 is marked or Item 955 is marked or Item 956 is marked or Item 957 is marked or Item 958 is marked or Item 959 is marked or Item 960 is marked or Item 961 is marked or Item 962 is marked or Item 963 is marked or Item 964 is marked or Item 965 is marked or Item 966 is marked or Item 967 is marked or Item 968 is marked or Item 969 is marked or Item 970 is marked or Item 971 is marked or Item 972 is marked or Item 973 is marked or Item 974 is marked or Item 975 is marked or Item 976 is marked or Item 977 is marked or Item 978 is marked or Item 979 is marked or Item 980 is marked or Item 981 is marked or Item 982 is marked or Item 983 is marked or Item 984 is marked or Item 985 is marked or Item 986 is marked or Item 987 is marked or Item 988 is marked or Item 989 is marked or Item 990 is marked or Item 991 is marked or Item 992 is marked or Item 993 is marked or Item 994 is marked or Item 995 is marked or Item 996 is marked or Item 997 is marked or Item 998 is marked or Item 999 is marked or Item 9999 is marked

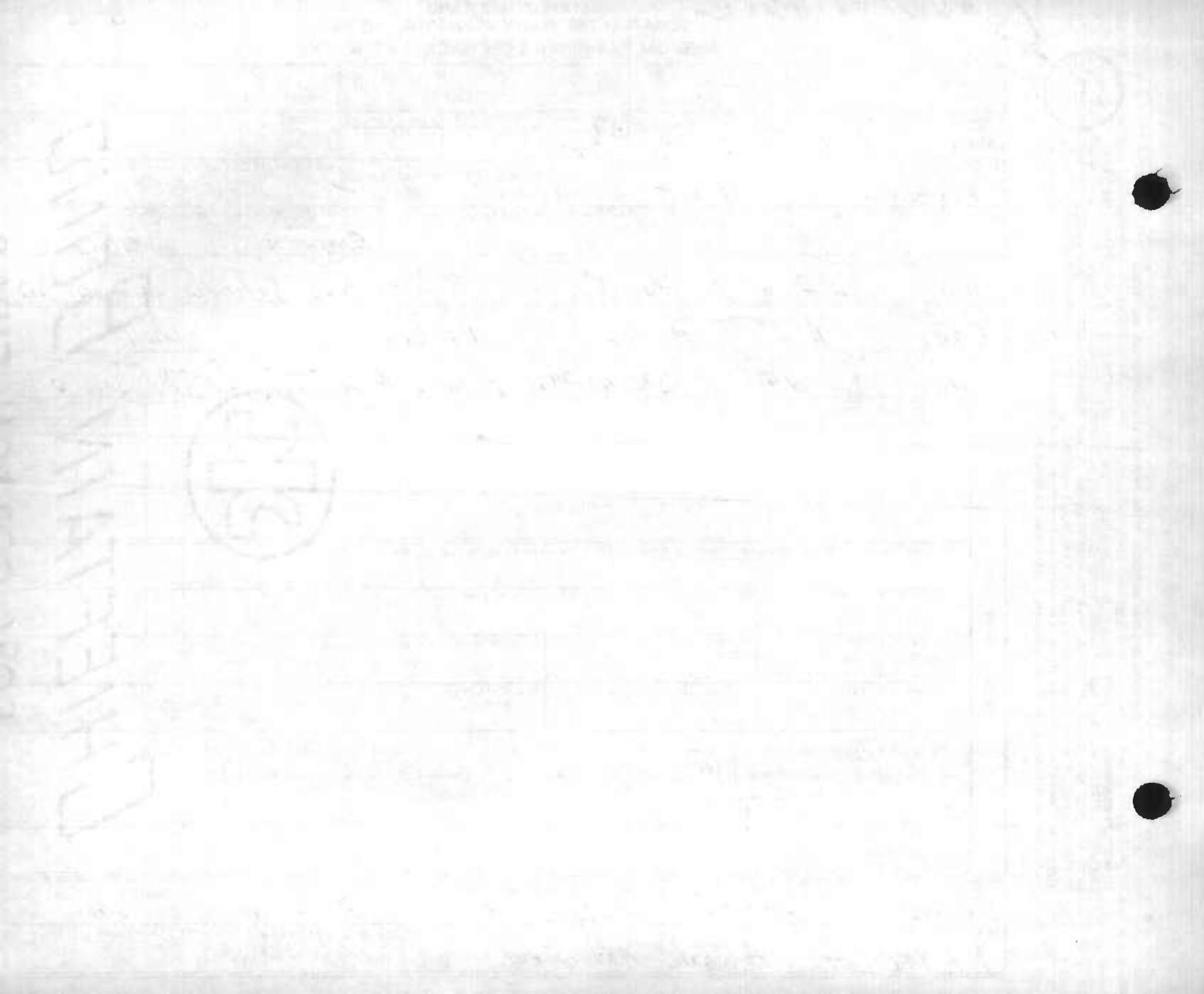
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												35 03463 EST	
1 - FOR REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST CLARA			MIDDLE Lee			LAST PEDDIE ORD			2a. DATE OF DEATH FEBRUARY 20, 1985		MONTH DAY YEAR
3. SEX Female		4. RACE White			5. DATE OF BIRTH June 17, 1920			6. AGE 64			2b. HOUR 1130 AM		
7a. BIRTHPLACE West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY			MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hostess			12b. KIND OF BUSINESS OR INDUSTRY Restaurant					
13a. STATE Maryland		13b. COUNTY Anne Arundel			13c. CITY OR TOWN Pasadena			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7729 Tiernan Drive 21122		
14. FATHER'S NAME Constantine J. Pauassis		15. MOTHER'S MAIDEN NAME Josepine			16. SOCIAL SECURITY NO. 233-38-8080			17. INFORMANT Mr. Otis A. Peddicord			ADDRESS Pasadena, Md. 7729 Tiernan Drive 21122		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Ca Gall Bladder oct 84												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH TAN 20, 84	
DOUE TO, OR AS A CONSEQUENCE OF (b) Liver Failure													
DUE TO, OR AS A CONSEQUENCE OF (c) Hepatic Cirrasis												4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21g. LOCATION STREET CITY OR TOWN COUNTY STATE					
21h. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Mountain & Tick Neck Roads Pasadena, Md. 21122			21j. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> Constantine J. Pauassis, M.D.			21k. MEDICAL DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>					
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) lost sow the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE Constantine J. Pauassis			22c. DEGREE M.D.			22d. ADDRESS 7300 RICHIE HIGHWAY, SUITE 500 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/23/85			23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Park			23d. LOCATION CITY OR TOWN Glen Burnie Anne Arundel Md.					
24. FUNERAL DIRECTOR NAME McCutty Funeral Home of Pasadena Mountain & Tick Neck Roads Pasadena, Md. 21122		25a. DATE REC'D. BY REGISTRAR FEB 25 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandell								



#6 Per F.N. 4/4/85 Km STATE OF MARYLAND  
FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
STATE REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03464

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
				Ronald	Kenton	Peoples	<input checked="" type="checkbox"/>	2/ 17/	1985		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS AND MONTHS) YEAR BIRTHDAY	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	white	9 2 47	39 46 yrs.				2/ 17/	1985		9:45	P M	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA		U.S.A.					Anne Arundel County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. KIND OF BUSINESS OR INDUSTRY					
Pasadena		520 Sylvview Drive			Employee		Westinghouse					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
Md.		A.A.C. Co.		Pasadena				520 Sylvview Dr. 21122				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Carl		A.		Peoples		Marjorie				Wall		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
No		VA		230-60-2961		Kenneth Peoples 2083 Justice Ct. Washington D.C. 20008						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Smoke and Soot Inhalation DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												
(b) _____ DUE TO, OR AS A CONSEQUENCE OF												
(c) _____												
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 9:2 P.M. 2/ 17/ 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject in housefire								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN 520 Sylvview Dr., Pasadena, AnneArundel, Md.								
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>		and in my opinion								
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER								
EXAMINER'S NAME TYPE OR PRINT)		Gregory R. Kauffman, M.D.		ADDRESS 111 Penn St.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 22-85	23c. NAME OF CEMETERY OR CREMATORY Westview Pk.	23d. LOCATION CITY OR TOWN Baltimore								
24. FUNERAL DIRECTOR T-A Hackett - Angrati		ADDRESS Md-21801	COUNTY STATE Md-									
25a. DATE REC'D. BY REGISTRAR FEB 22 1985		25b. REGISTRAR'S SIGNATURE John J. Pendleton										
BP		DHMH - 17 (VR A15 ME (5))										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, copy should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1-2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 3 4 6 5			
												REG. NO.			
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
John Loving Perry									2-2-1985			7:00 PM			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		Caucasian		12-16-1908			76 YRS.			MONTHS	DAYS	HOURS	MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH								
Richmond Va		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Anne Arundel County			MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Edgewater		Pleasant Living Convalescent Ctr										Plant Super.		Tin	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Md.				Pasadena			YES <input type="checkbox"/> NO <input type="checkbox"/>			1900 Schwartz Rd. 21122					
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Unknown		IDA													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn.		16b. SOCIAL SECURITY NO		17 INFORMANT			ADDRESS								
		212-05-1415		Mrs. Gladys Perry - Same as #13											
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Parkinsons												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Charles W. Finner		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED							
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2/2/85			23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE FEB 06 1985 J. G. Leidson-Randall							

BP\_\_\_\_\_

DHMH-16 25M  
(VRA 15, 4) 1/79

1

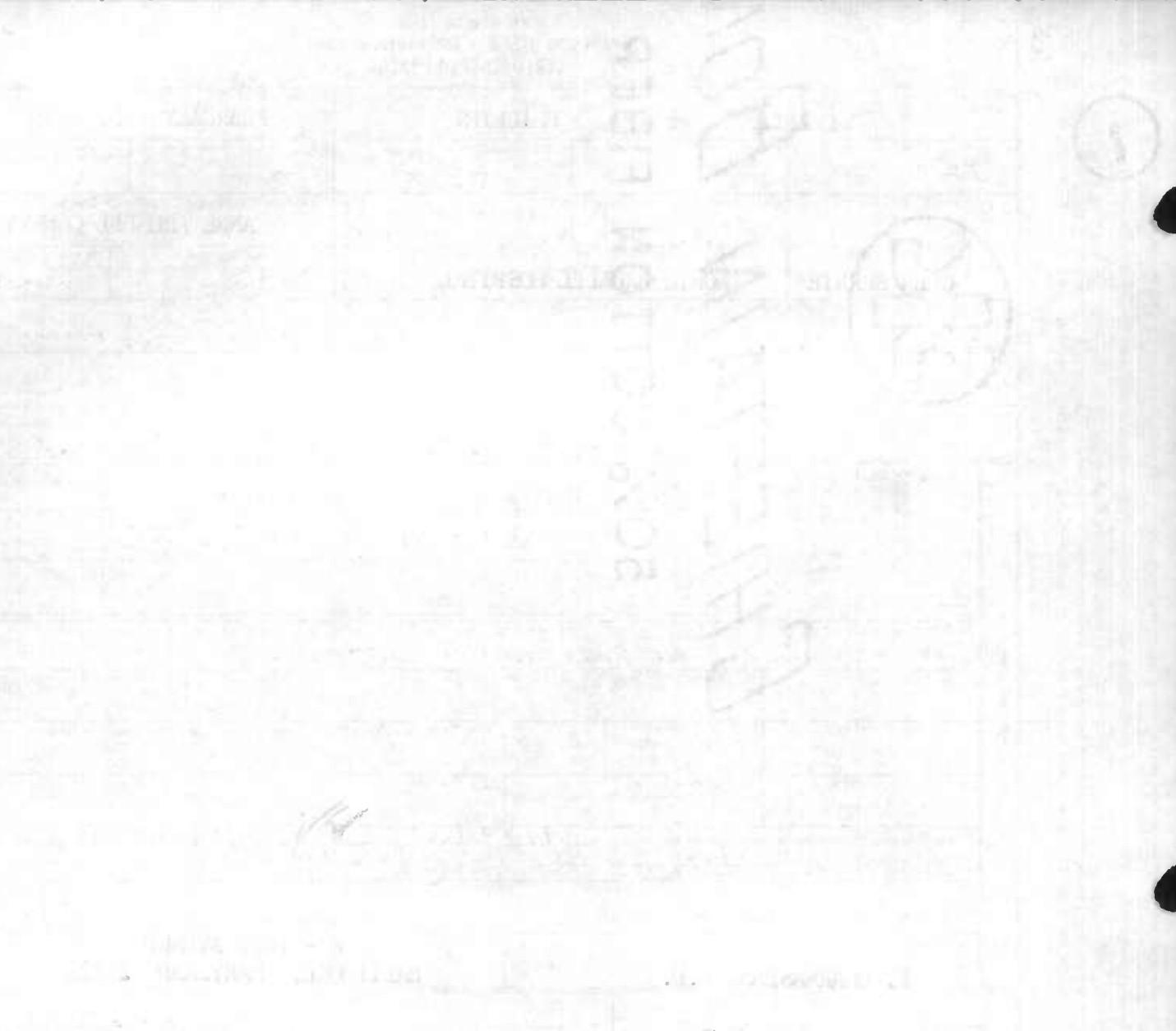


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or left blank, then any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8503466	EST					
												REG. NO.						
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)											2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
	CHARLES			MIDDLE			LAST			FEBRUARY		5,	1985	250 AM				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	8. IF UNDER 24 HRS													
Male	White	MONTH JUNE	DAY 26	YEAR 1913	71	YRS.	MONTHS	DAYS	HOURS	MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	MD.												
Maryland		U.S.		Anne Arundel County														
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL											Painter		Building			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE														
Maryland	A. A.	Pasadena	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	256 Wanda Road, (21122)														
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST											
	George		Phillips	Mary			Krapp											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	21213	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
No	213-05-7572	Wm. J. Stecker, 3325 Lawnview Ave., Baltimore, Md																
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).)	PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>BRONCHIOGENIC CARCINOMA</u> DOUE TO, OR AS A CONSEQUENCE OF <u>BRAIN METASTASES</u>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	{ (b) { DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a	<u>COPRODUCTIVE obstructive pulmonary disease.</u>																	
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE												
22a. I certify that (I) (this hospital) attended the deceased from <u>1/29/</u> , 19 <u>85</u> , to <u>2/05/</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/04/</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													22c. DATE SIGNED <u>2/05/1985</u>					
22b. SIGNATURE <u>K. Dharmasena, M.D.</u>													22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) K. DHARMASENA, M.D.													22f. ADDRESS 8 - 16ST AVENUE BALTIMORE, MARYLAND 21225					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 2-8-85	23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park	23d. LOCATION CITY OR TOWN Woodlawn, Baltimore Co., MD	COUNTY	STATE												
24. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hg., Baltimore, MD. 21225														25a. DATE REC'D. BY REGISTRAR FEB 7 1985		25b. REGISTRAR'S SIGNATURE <u>Jane Davidson-Randall</u>		
DHMH - 16 60M 7/84 (VRA 15, 4)																		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked **✓**, show any injury, or other traumatic event, the medical examiner must be informed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 03461			
										REG. NO.			
1 - STATE REGISTRAR			I. DECEASED NAME FIRST MIDDLE LAST							2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
			Hilda A. Powers							2 - 8-85		2:00 PM	
3 SEX			4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			Caucasian		7 - 22 - 96			88 yrs.			MONTHS DAYS		
7a BIRTHPLACE STATE OR FOREIGN COUNTRY			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 4 HRS		
Pennsylvania			United States					Anne Arundel County MD.			MONTHS DAYS HOURS MIN.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Annapolis			Anne Arundel General Hospital		CLERK			Shipping Co.					
13a STATE			13b COUNTY		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE					
Maryland			Anne Arundel		Arnold			671 White Swan Dr. 21012					
14. FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Charles			Alicia Partington Walker										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS				
			169-18-0054			Thomas W. Powers (same as 13)							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			REASON FAILURE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			(b) Septic + Endocarditis										
			(c) Dystocia, insufflary										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
Pneumonia			Congestive Heart Failure										
19a DATE OF OPERATION 2/1/85			19b CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel obstruction - Hernia, Inguinal			20b AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED			ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1631			21f LOCATION STREET 85			CITY OR TOWN 218 COUNTY 85 STATE				
22a I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.			19 85			to 19 85			, that (I) (we) last				
22b SIGNATURE Dr. John Mawhaffay			22c DEGREE										
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John Mawhaffay			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e ADDRESS ANNAPOLIS, MD.			22f DATE SIGNED 3/18/85				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE FEB. 12, 1985			23c NAME OF CEMETERY OR CREMATOR Y St. Dennis Church Cemetery Havertown			23d LOCATION CITY OR TOWN HAVERTOWN COUNTY DELAWARE PA.				
24 FUNERAL DIRECTOR NAME Barranco Funeral Home			561 RITCHIE HWY. ADDRESS SEVERNA PARK, MD.			25a DATE REC'D. BY REGISTRAR FEB 11 1985			25b REGISTRAR'S SIGNATURE Julia Davidson-Pendleton				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Board of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03468					
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR PM					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			Feb. 10, 1985							2:20 M		
Charles Francis Proctor															
3. SEX male			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
						June 26, 1911			73 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Shady Side Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.						
10. CITY OR TOWN OF DEATH Shady Side			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1664 Cedar Lane			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waterman			12b. KIND OF BUSINESS OR INDUSTRY sea food						
13a. STATE Md.			13b. COUNTY A.A. Co.			13c. CITY OR TOWN Shady Side			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1664 Cedar Lane 20764			
14. FATHER'S NAME FIRST George MIDDLE W. LAST Proctor			15. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE Lee LAST												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 43-44			17. INFORMANT			ADDRESS						
						Grace L. Proctor same as 13e.									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Methotetetic Gladder Ca.</i>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>8-10</u> , 19 <u>84</u> , to <u>2-10</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1-8</u> , 19 <u>85</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													22b. SIGNATURE <i>A. Hardesty</i> DEGREE		
22c. PHYSICIAN'S NAME (TYPE OR PRINT)													ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>		
													22d. DATE SIGNED <u>2-11-85</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/12/85			23c. NAME OF CEMETERY OR CREMATORIAL St James			23d. LOCATION CITY OR TOWN Lothian			COUNTY A.A. Co. Md. STATE			
24. FUNERAL DIRECTOR NAME <i>Hardesty</i> ADDRESS 12 Ridgely Ave.			25a. DATE REC'D. BY REGISTRAR FEB 11 1985			25b. REGISTRAR'S SIGNATURE <i>J. Hardesty</i>									
Hardesty Funeral Home Ann. Md. 21401															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

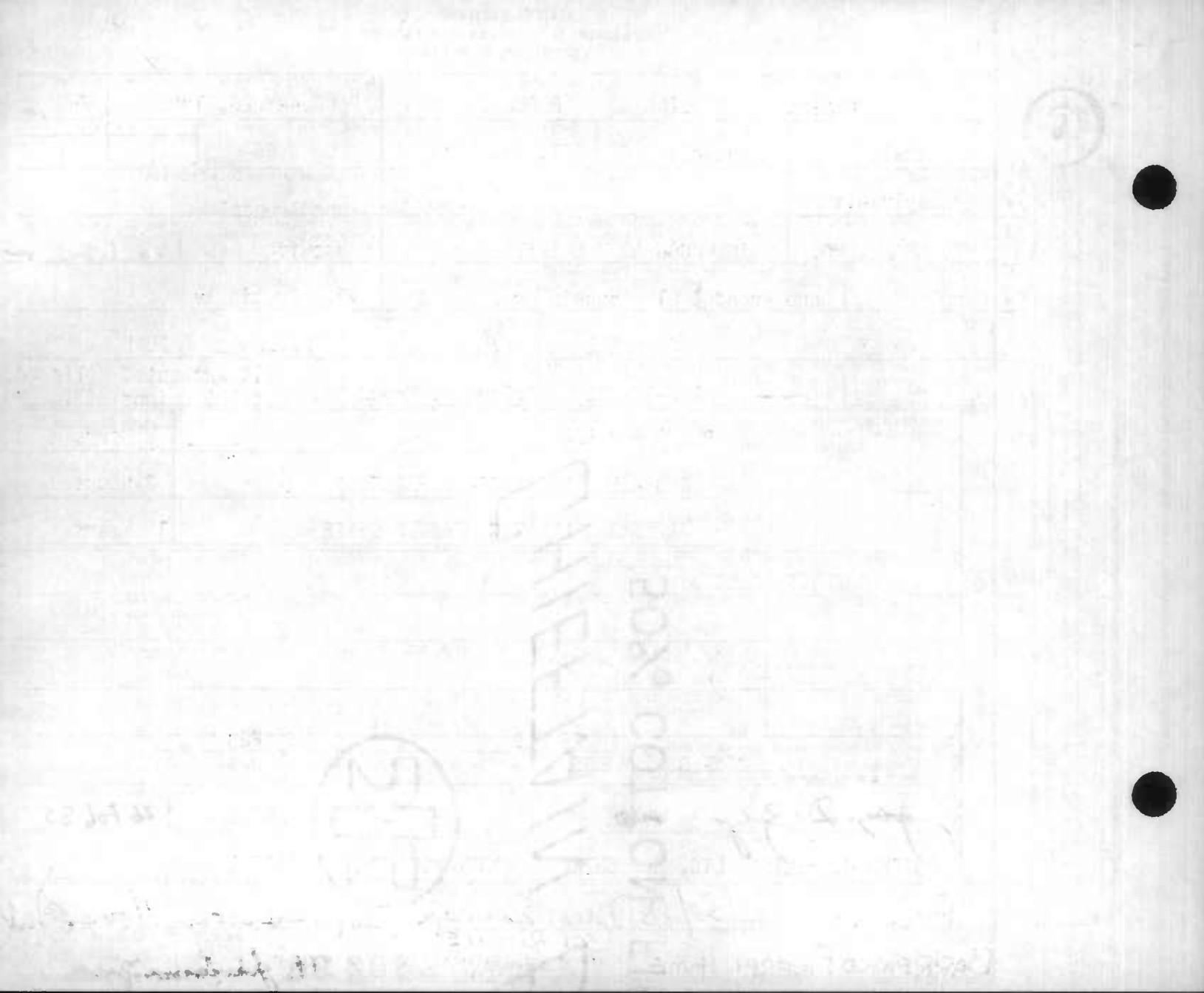
IMPORTANT: If Item 21 is marked on Item 18, show any injury, or other traumatic event, the medicare examiner will be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 03469

1. DECEASED NAME (TYPE OR PRINT)	FIRST <b>CLAIRe</b>	MIDDLE <b>PAULINE</b>	LAST <b>PROUD</b>	2a. DATE OF DEATH <b>FEBRUARY 26, 1985</b>	MONTH YEAR	DAY	YEAR	2b. HOUR <b>0040 PM</b>			
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>OCT. 24, 1919</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>65 YRS.</b>	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b>	MD.							
10. CITY OR TOWN OF DEATH <b>FT. MEADE, MD.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>KIMBROUGH ARMY HOSPITAL</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>@ home</b>								
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>7708 Brutin Avenue 21061</b>							
14. FATHER'S NAME FIRST <b>JAMES</b>	MIDDLE	LAST <b>CAMPBELL</b>	15. MOTHER'S MAIDEN NAME <b>Anne</b>	MIDDLE <b>Mal</b>	LAST <b>RUPP</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>162-12-7336</b>	17. INFORMANT <b>Nelson A. Proud Sr. - Apt 303 Owings Mills, MD</b>	110 Enchanted Hills Rd.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROBABLE MYOCARDIAL INFARCTION</b>						3 Hours					
DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>						15 Years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>DIABETES MELLITUS</b>											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>25 FEB 1985</b> to <b>26 FEB 1985</b> , that (I) (we) last saw the deceased alive on <b>26 FEB 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <input type="checkbox"/> view the body after death.											
22b. SIGNATURE <b>Joseph D. Zeligs, M.D.</b>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>26 Feb 85</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH D. ZELIGS, LTC, MC, CHIEF</b>	22e. ADDRESS <b>KIMBROUGH ARMY HOSPITAL</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>2/28/85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Meadebridge Mtn Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Darby, Howard</b>	COUNTY	STATE						
24. FUNERAL DIRECTOR NAME <b>BARRANCO FUNERAL HOME</b>	ADDRESS <b>501 Ritchie Hwy SEVERNAK MD</b>	25a. DATE REC'D BY REGISTRAR/REGISTRAR'S SIGNATURE <b>MAR 01 1985 J. Zeligs, M.D.</b>									



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**MEDICAL CERTIFICATION**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03470					
1. DECEASED NAME (TYPE OR PRINT)				FIRST Harold	MIDDLE Franklin	LAST Pugh	2a. DATE KNOWN OF ESTI. DEATH MATED				MONTH 19	DAY	YEAR	2b. HOUR M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD				MONTH 2d. HOUR	DAY	YEAR	2d. HOUR M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH AA County							
10. ID CITY OF TOWN OF DEATH Glen Burnie				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel				12a. USUAL OCCUPATION (TYPE OF WORK) Machinist				12b. KIND OF BUSINESS (OR INDUSTRY) U.S.C.G.			
13a. STATE md.		13b. COUNTY AA		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 188 Carroll Rd.							
14. FATHER'S NAME FIRST James				15. MOTHER'S MAIDEN NAME FIRST Mabel											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. W.W. II 215-03-0408				17. INFORMANT Anna M. Pugh				ADDRESS Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>										DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i>					
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET							
								CITY OR TOWN							
								COUNTY							
								STATE							
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>William P. Jones, M.D.</i>		TITLE (SPECIFY) M.D. Deputy								MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.		ADDRESS 695 America Crt., Davidsonville, Md. 21035								DATE SIGNED 2/9/85					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/12/85				23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem Park				23d. LOCATION CITY OR TOWN Glen Burnie			
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md								25a. DATE REC'D. BY REGISTRAR FEB 13 1985				25b. REGISTRAR'S SIGNATURE <i>Jane Dawson-Jones</i>			
BP _____															
DHMH - 17 (VR A15 ME (5))															
20M 4/B2															



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新編古今圖書集成

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign in my book.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 03471				
1 - FOR STATE REGISTRAR			1a. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			<i>Herbert Wentworth Quartley</i>						<i>Feb 17 1985</i>			<i>8 PM</i>				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
<i>Male</i>			<i>CAUCASIAN</i>			<i>Aug 25 1904</i>			<i>80</i>			<i>YRS</i>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
<i>Baltimore, MD</i>			<i>US/3</i>						<i>Anne Arundel</i>							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
<i>Arnold</i>			<i>709 Cottage DRIVE</i>			<i>Data Processor</i>			<i>St. of Md Income Tax</i>							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			21012	
<i>Maryland</i>			<i>Anne Arundel</i>			<i>Arnold</i>						<i>709 Cottage DRIVE</i>				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
<i>Herbert Wentworth Quartley Sr.</i>			<i>MAY Tolley</i>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Colon</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 years</i>				
No			<i>212 01 9358</i>			<i>Jessie Louise Quartley</i>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Colon</i>			DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION <i>Apr 1 1978</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer of Colon</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 1 1979</i> to <i>Feb 12 1985</i> , that (I) (was) last saw the deceased alive on <i>Jan 5 1985</i> , and that in (my) (opinion) death occurred on the date and hour and from the causes stated above, (I) (was) (did) not view the body after death.																
22b. SIGNATURE <i>J.C. Cullis MP</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>Feb 17, 1985</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J.C. Cullis</i>			22e. ADDRESS <i>Riggs Rd. Severna Park MD.</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>FEB 20, 1985</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>MEADOWRIDGE CEMETERY</i>			23d. LOCATION CITY OR TOWN <i>Dorsey, Howard MD</i>							
24. FUNERAL DIRECTOR NAME <i>BARRANCO FUNERAL HOME SEVERNA PARK, MD</i>			25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Jean Davidson Pendleton</i>													



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 12 AND 12 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PHESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REPROVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03472

1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	12	DAY	85	YEAR	2b. HOUR
<i>Maxine</i>			C		<i>Rawes</i>	<input checked="" type="checkbox"/>	19					19
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	2	12	19	85	2d. HOUR
F	White	2 27 27	57 yrs.			2d. HOUR	2045					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH						
Texas		USA				Anne Arundel County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis		Anne Arundel General Hospital			Home maker			own home				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS		MD.			
Maryland		Anne Arundel		Gambrills		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2490 Bell Branch Road		21054			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
Alvin		M.	Cole	Jean		Mae	Choate					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS						
no		219-12-4767		Robert M. Rawes		2490 Bell Branch Rd.			Gambrills, Maryland			
21054												
APPROXIMATE NUMBER BETWEEN ONSET AND DEATH												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i>Respiratory Failure and Hypotension</i> DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE		<i>J. E. Wheeler</i>		M.D. <i>Dip.</i>		MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)		TITLE (SPECIFY) <i>JAMES E. WHEELER</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE February 14, 1985		23c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood, Prince George's, MD		COUNTY		STATE		
Burial		1985		Ft. Lincoln Cemetery		Brentwood, Prince George's, MD						
24. FUNERAL DIRECTOR NAME Beall Funeral Home		6000 Annapolis Road Bowie, MD 20715-3043		25a. DATE REC'D. BY REGISTRAR FEB 14 1985		25b. REGISTRAR'S SIGNATURE <i>Gilia Davidson-Randall</i>						

BP \_\_\_\_\_

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(VR A15 ME (5))  
20M 4/B2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 03473 EST	
1 - FOR REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST MARGARET	MIDDLE E	LAST REESE			2a. DATE OF DEATH MONTH FEBRUARY		DAY 03, 1985	2b. HOUR 100 PM	
3. SEX <b>F</b> Female		4. RACE <b>W</b> White		5. DATE OF BIRTH MONTH 04			YEAR 07 09			6. AGE (IN YEARS LAST BIRTHDAY) 76 yrs.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THE PREVIOUS LINE, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Personnel Officer				12b. KIND OF BUSINESS OR INDUSTRY Industrial			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5728 1st Avenue 21227		
14. FATHER'S NAME FIRST Francis		MIDDLE		LAST LeCompte			15. MOTHER'S MAIDEN NAME ADDRESS				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW2		17. INFORMANT Austin Reese			18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardio Respiratory arrest.</i>				
											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
											YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Oscar P. Pedel. Jr.</i>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED SUITE 105				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDULLAH SHAMS PIRZADEH, M.D.		22e. ADDRESS 525 HOSPITAL DRIVE, SUITE 105 GLEN BURNIE, MARYLAND 21061									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 2/6/85		23c. NAME OF CEMETERY OR CREMATORIAL Church Hill Cemetery			23d. LOCATION CITY OR TOWN Church Hill		COUNTY Queen Annes	STATE Md.	
24. FUNERAL DIRECTOR NAME Ambrose, Inc.		ADDRESS 1328 Sulphur Spring Road		25a. DATE REC'D. BY REGISTRAR FEB 4 1985			25b. REGISTRAR'S SIGNATURE <i>La Davidson-Pedell</i>				

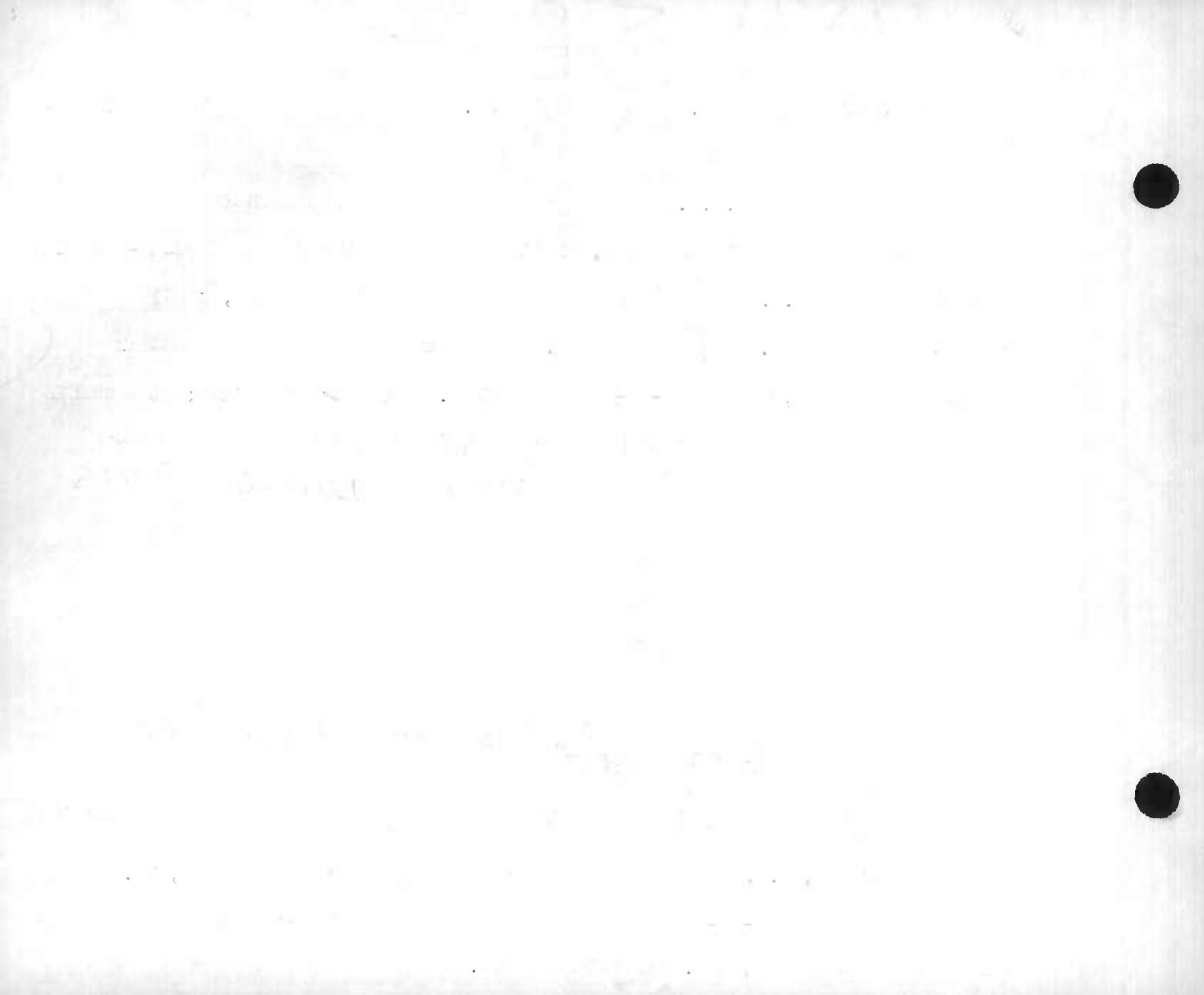


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												03474			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
JOHN A. REGAN JR.						02 20 85			11:53 P.M.						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
MALE		WHITE		06 11 28			56 YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
MARYLAND		U.S.A.					ANNE ARUNDEL MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
GLEN BURNIE		32 ELM DRIVE, 21061		BUTCHER			SELF-EMPLOYED								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN GLEN BURNIE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 32 ELM DRIVE, 21061					
14. FATHER'S NAME FIRST JOHN		MIDDLE A.		LAST REGAN, SR.			15. MOTHER'S MAIDEN NAME FIRST MARTHA			MIDDLE ECKART LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) YES WWII, KOREA		16c. ADDRESS 21061			17. INFORMANT EVELYN A. REGAN			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, General</u>															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of prostate</u>												2 yrs			
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Mar 10 84			21f. LOCATION STREET CITY OR TOWN COUNTY STATE Feb 20 85									
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 22</u> 19 <u>85</u> , to <u>March 10</u> 19 <u>84</u> , to <u>Feb 20</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Jan 22</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Joseph Taler, M.D.</u>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>Feb 22, 1985</u>									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH TALER, M.D.			22f. ADDRESS 95 AQUAHART ROAD; GLEN BURNIE, MD. 21061												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 02-25-85			23c. NAME OF CEMETERY OR CREMATORIAL LOUDON PARK			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND						
24 FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.			ADDRESS 4107 WILKENS AVE.			25a. DATE REC'D. BY REGISTRAR FEB 22 1985			25b. REGISTRAR'S SIGNATURE <u>John Taler</u>						



*6/11/24*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2d HOUR	
FRANKLIN			Shephend	RIDGEWAY		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	19	1985		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d HOUR	
Male	White	Dec. 8, 1934	50 yrs.			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	23	1985	10:30 AM	
7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland						Anne Arundel County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis			field-between Whitehall & Colbert Rds.			Retired			Telephone Co.				
13a. STATE MD			13b. COUNTY A.A.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2140 1/2 619 Ridgely Avenue				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Sarah Eilen Sears			121 Triton Beach Road					
Frank Napoleon			Ridgeway		16b. SOCIAL SECURITY NO. 1951-1959			Cheryl Bowen-Edgewater, MD 21037					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 1951-1959			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<input checked="" type="checkbox"/>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alcoholism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?							
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.												DATE SIGNED 2-24-85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE March 2, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Bluff			23d. LOCATION CITY OR TOWN Annapolis			COUNTY A.O.	STATE MD
24. FUNERAL DIRECTOR NAME Taylor Funeral Director-Annapolis, MD			ADDRESS			25a. DATE REC'D. BY REGISTRAR MAR 4 1985			25b. REGISTRAR'S SIGNATURE <i>Wilson Pendleton</i>				
BP													
DHMH - 17 (VR A15 ME (5))													

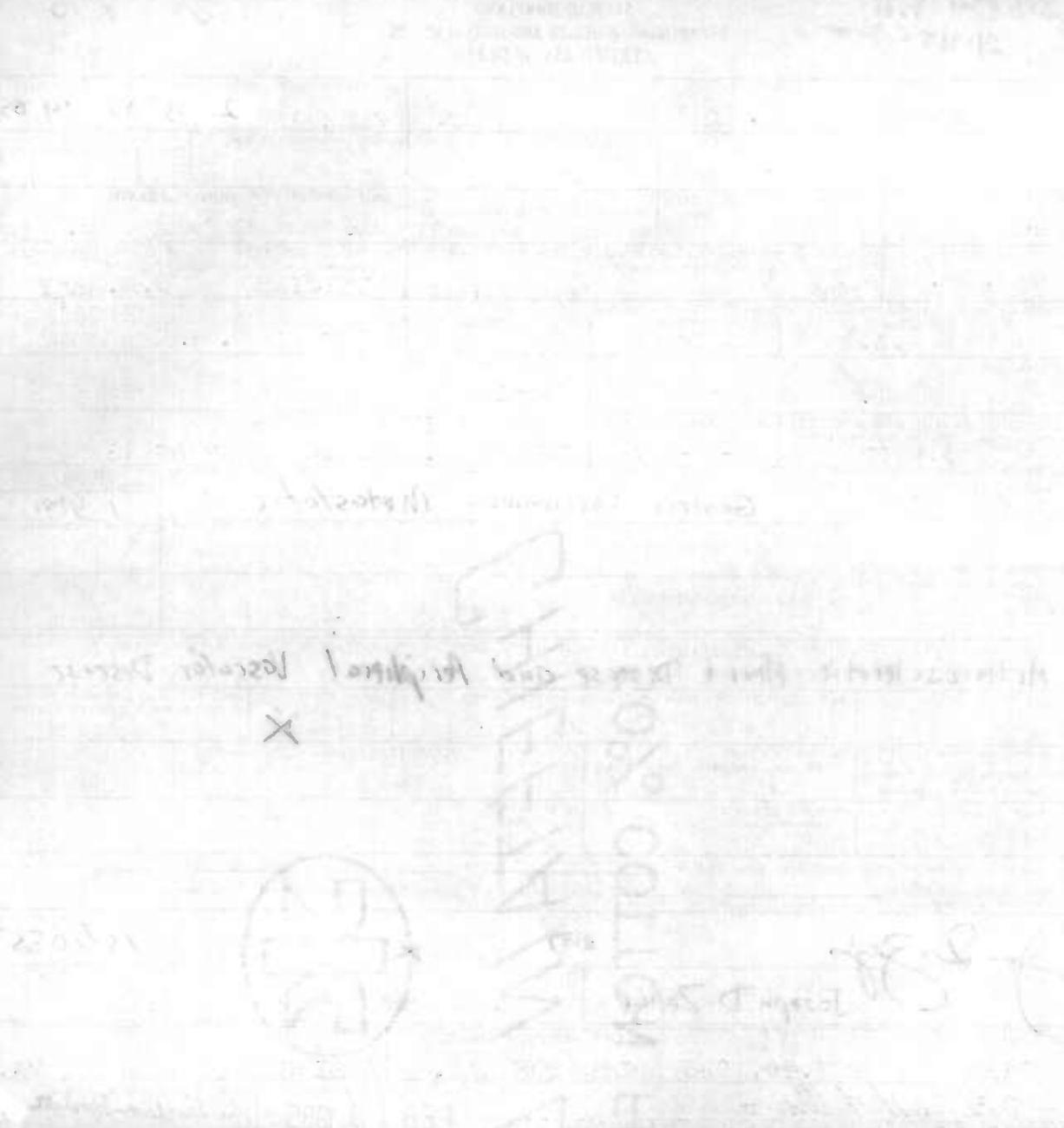


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85	03	476
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Edward PAUL Rostek Sr.						FEBRUARY 15, 1985						14 05 M		
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		
Male			WHITE			FEB. 02, 1920						IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			USA									Anne Arundel County, Md. MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Ft. Meade, Md.			Kimbrough Army Community Hospital									MUSICIAN		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Maryland			A.A.			Glen Burnie						8 D Street N. W. Glen Burnie		
21061														
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Peter			P.	Rostek		Caroline					Sobol			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT (WIFE)			ADDRESS					
Yes			WW II			213-05-2305			AUDREY O. ROSTEK			SAME AS 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Carcinoma - Metastatic</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>		
DUE TO, OR AS A CONSEQUENCE OF (b) _____														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____														
DUE TO, OR AS A CONSEQUENCE OF (d) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Arteriosclerotic Heart Disease and Peripheral Vascular Disease</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>J. D. Zelig</u>			22c. DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>15 Feb 85</u>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph D. Zelig</u>			22f. ADDRESS Kimbrough Army Community Hospital											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>at</u> BURIAL <u>FEB. 20, 1985</u>			23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NAT.			23d. LOCATION CITY OR TOWN ARLINGTON			COUNTY	STATE VA.	
24. FUNERAL DIRECTOR NAME <u>John J. Hallinan</u>			ADDRESS KIMBROUGH ARMY COMMUNITY HOSPITAL, HOME, GLEN BURNIE, MD. 21061			25a. DATE REC'D. BY REGISTRAR <u>FFB 19 1985</u>			25b. REGISTRAR'S SIGNATURE <u>Le Davidson</u>					



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 22 shows any injury or other traumatic event, the medical examiner must be consulted before the death certificate is signed.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

03471

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Louise E. Rüdiger</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Feb 2 1985</b>			2b. HOUR <b>12 10 P.M.</b>	
3. SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4-15-99</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b>			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE COUNTRY <b>M.S.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>A.A. Co</b>				
10. CITY OR TOWN OF DEATH <b>Edgewater</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pleasant Living Conv. Ctr.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PAYROLL CLERK COURIER SERV.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>nn MD.</b>	
13a. STATE <b>MD</b>	13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>SEVERNA PK</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>207 KATHY CT. 21146</b>			
14. FATHER'S NAME FIRST <b>JACOB</b>	MIDDLE <b></b>	LAST <b>AUGUST</b>	15. MOTHER'S MAIDEN NAME <b>MARIE</b>	MIDDLE		LAST <b>ALBRECHT</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. <b>138205018</b>	17. INFORMANT <b>MARYLYN BONGARD - ABOVE</b>	ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASCVD</b>							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Heart failure</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>probable pneumonia</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (II) (we) lost sow the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles W. Kinser</b>			DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>2-2-85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES W. KINSER</b>			22e. ADDRESS <b>Annapolis, MD 21401</b>				
23a. BURIAL, CREMATION, REMOVAL CEREMONY	23b. DATE <b>2-4-85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Westview Crem Westview Park</b>	23d. LOCATION STREET <b>Severna Park, MD</b>	23e. DATE REC'D. BY REGISTRAR <b>Feb 6 1985</b>	23f. REGISTRAR'S SIGNATURE <b>Susan L. Kinser, R.N.</b>		
24. FUNERAL DIRECTOR NAME <b>Robert J. Lananeo</b>	ADDRESS <b>Severna Park, MD</b>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be delivered to the hospital or attending physician. Then please remove carbon paper. Pages 1 & 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, prior to a burial, cremation, or removal.

BP \_\_\_\_\_  
DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 03418

EST

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LORETO CARIDAD RUIZ</b>				2a. DATE OF DEATH <b>FEBRUARY 7, 1985</b>	MONTH YEAR	DAY	YEAR	2b. HOUR <b>10:50 M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 10, 1900</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>84 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CUBA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LIBRARIAN (RET)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BON SECOUR HOS.</b>	
13a. STATE <b>MD</b>	13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>PASADENA</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>276 SILLERY BAY RD. 21122</b>			
14. FATHER'S NAME FIRST <b>JOSE</b>		MIDDLE <b></b>	LAST <b>PEREZ</b>	15. MOTHER'S MAIDEN NAME FIRST <b>CARMELA</b>		MIDDLE <b></b>	LAST <b>SANCHEZ</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT (SON) <b>DR. OCTAVIO A. RUIZ SAME AS 13</b>		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcerone of the lung -</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>Liver metastasis - Hepatic failure - Phlebitis C lung - pneumonia</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) 1/23/85					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1/23/85	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			21g. DATE 1/23/85		
22a. I certify that (I) (this hospital) intended the deceased from 1/23/85 to 2/7/85, that (I) (we) last saw the deceased alive on 1/23/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not (not) view the body after death.								
22b. SIGNATURE <b>Jorge B. Ramirez, M.D.</b>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <b>2/7/85</b>			
22e. ADDRESS <b>7845 OAKWOOD ROAD #205 GLEN BURNIE, MARYLAND 21061</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>FEB. 9, 1985</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>DRUID RIDGE CEM</b>			23d. LOCATION CITY OR TOWN <b>Pikesville</b>	COUNTY <b>Balto.</b>	STATE <b>MD</b>
24. FUNERAL DIRECTOR NAME <b>R. H. Hopkins</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1985</b>			25b. REGISTRAR'S SIGNATURE <b>Heather Anderson-Pender</b>			
ADDRESS <b>SINGLETON FUNERAL HOME GLEN BURNIE, MD 21061</b>								



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

5 0 3 4 7 9

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
1 - FOR STATE REGISTRAR											REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Madeleine</i>	MIDDLE <i>Barrett</i>	LAST <i>Crawford Sadler</i>	2a DATE OF DEATH			MONTH 2	DAY 19	YEAR 85	2b HOUR 3:00 P.M.					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
			caucasion			MONTH DAY YEAR Sept. 23, 1901			83			MONTHS	DAYS	HOURS	MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			Anne Arundel MD.					
New Jersey			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Anne Arundel MD.					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			Edgewater Pleasant Living Convalescent Ctr. Homemaker Home					
Wash. DC			Washington			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE			99044 3722 Albermarle St. NW					
14. FATHER'S NAME			FIRST <i>Charles</i>	MIDDLE <i>J.</i>	LAST <i>Barrett</i>	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			ADDRESS			<i>2501 Carrollton Rd.</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE) <i>aspiration pneumonia</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			<i>Marjorie P. Crain-Annapolis, MD 21403</i>		
NO			519-60-4263						(b) <i>Alzheimers disease</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(c) <i></i>			DUE TO, OR AS A CONSEQUENCE OF								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>10-24 1983</i> to <i>2-19 1985</i> , that (I) (we) last saw the deceased alive on <i>2-13 1985</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) see the body after death.																	
23a. SIGNATURE			23b. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			23c. DATE SIGNED								
<i>John B. Horne Jr.</i>												2-19-85					
24a. PHYSICIAN'S NAME, TYPE OF PRACTICE			24b. ADDRESS			24c. BURIAL, CREMATION, REMOVAL (CITY)			24d. DATE			24e. NAME OF CEMETERY OR CREMATORY			24f. LOCATION CITY OR TOWN		
Son B. Horne MD			Annapolis MD 21061			Burial			Feb. 22, 1985			Arlington National Cemetery			Arlington VA		
24g. FUNERAL DIRECTOR NAME			ADDRESS			24h. DATE REC'D. BY REGISTRAR			24i. REGISTRAR'S SIGNATURE								
Taylor Funeral Chapel Annapolis MD						FEB 21 1985						<i>Lia Davidson-Randall</i>					

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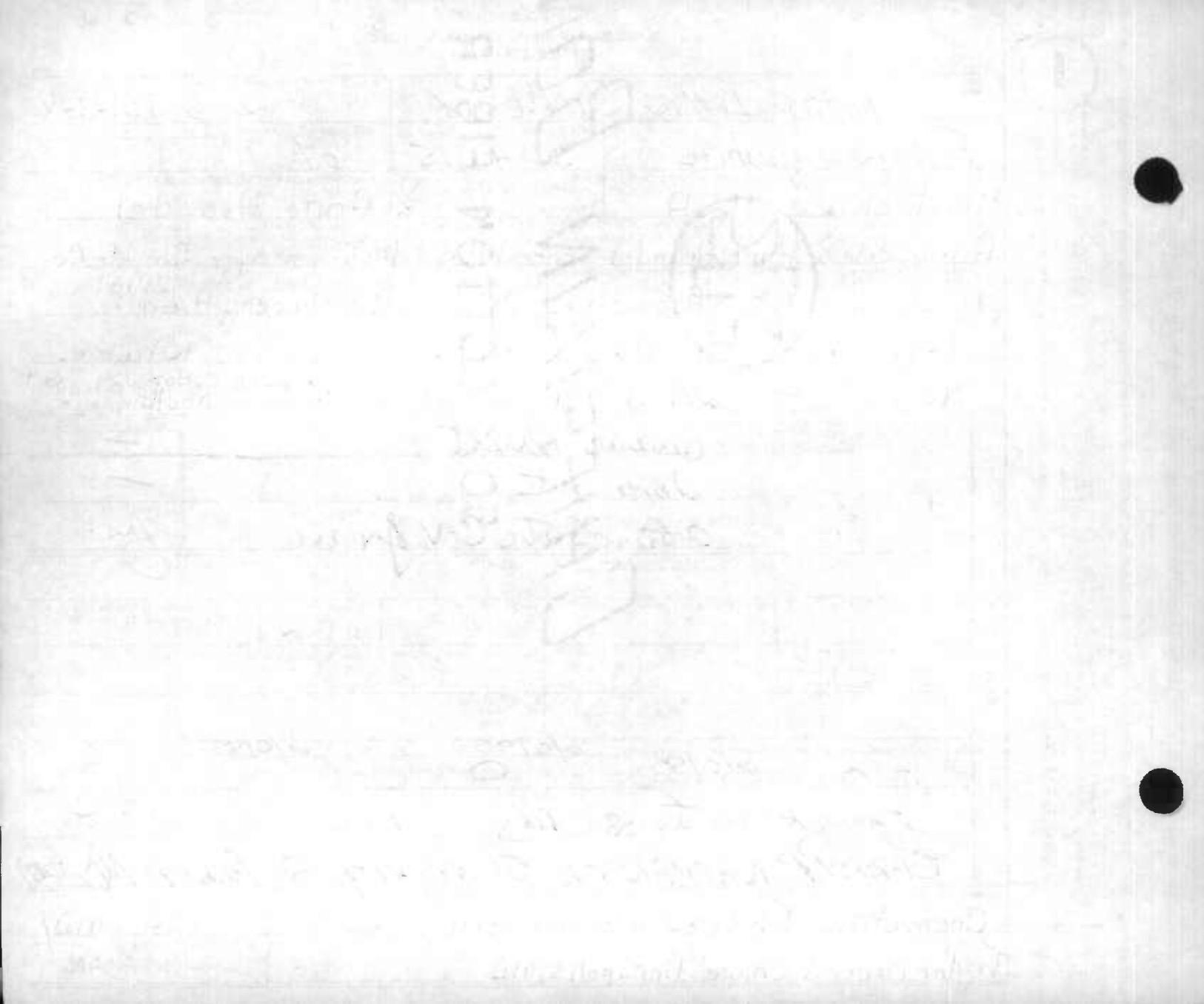
1000 feet above sea level. The water is  
clear and cold. The air is very dry.  
The vegetation consists of pine trees,  
junipers, and some small shrubs.  
There is no grass or flowers.  
The soil is very poor and rocky.  
There is no water in the streams.  
The water is clear and cold.  
The air is very dry.  
The vegetation consists of pine trees,  
junipers, and some small shrubs.  
There is no grass or flowers.  
The soil is very poor and rocky.  
There is no water in the streams.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85 03480									
												REG. NO.									
1. FOR STATE REGISTRAR			2d. DATE OF DEATH MONTH DAY YEAR									2b. HOUR									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Arta Irma Sandefur						Female			white			3 4 15			69					2348M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.									
Kentucky			USA																		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY						
Annapolis			Anne Arundel General Hospital Ref. Cookkeeper Concrete Co																		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE MD			13b. COUNTY A.A.			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 18 Murray Avenue 21401						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME Arta			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 236-26-9494			17. INFORMANT Judith Hassett-Assist. New Hampshire			ADDRESS R. Route 2, Box 329 03804						
George			Felix																		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. DUE TO, OR AS A CONSEQUENCE OF (b) Acute MI									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			19. DUE TO, OR AS A CONSEQUENCE OF (c) Other occlusive C-V disease																		
20. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																					
21a. MEDICAL CERTIFICATION			21b. DATE OF OPERATION			21c. CONDITION FOR WHICH OPERATION WAS PERFORMED			21d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21f. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21g. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21h. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21i. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21j. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21l. LOCATION STREET			21m. CITY OR TOWN			21n. COUNTY			21o. STATE						
22a. I certify that (s) (this hospital) attended the deceased from <u>2/6/85</u> , 19, to <u>2/6/85</u> , 19, that (s) (we) last saw the deceased alive on <u>2/6/85</u> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (s) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE Barry R. Nathanson MD			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 2/6/85															
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Barry R. Nathanson			22f. ADDRESS 51 Franklin St Annapolis MD 21401																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Feb 8, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill			23d. LOCATION CITY OR TOWN Sutherland			23e. COUNTY PG			23f. STATE MD						
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD			25a. DATE REC'D. BY REGISTRAR FEB 8 1985			25b. REGISTRAR'S SIGNATURE Maria Davidson-Rendell															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or physician in charge, it should be detached for use as the burial/transit permit. Then please remove carbon paper. If you are unable to bury, cremate, or remove the body within 72 hours after death, contact the State Dept. of Health and Mental Hygiene or your funeral director.

IMPORTANT: If Item 21 is marked "Yes" to any injury, or other traumatic event, the medical certifying physician must be notified at once.

1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 03.81

1. DECEASED NAME FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Gladys H. Schlotter				2 - 24 - 85	6:30 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Female		White		12 - 8 - 11	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Michigan		USA		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Anne Arundel General Hospital		12a. USUAL OCCUPATION Homemaker	
13a. STATE MD		13b. COUNTY A.A.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13c. CITY OR TOWN Annapolis				13e. STREET ADDRESS / ZIP CODE 2123 Lury Lane 21401	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		12b. KIND OF BUSINESS OR INDUSTRY Hirdes	
John H. Etterbeck		Grace			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. - 552-09-5997		17. INFORMANT Carla J. Mites - same as #13	
NO					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intershuttle premium					
DUE TO, OR AS A CONSEQUENCE OF (b) (c)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Long. ht brns					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost sow the deceased alive on 3/23/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED 2/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Biern, MD		22e. ADDRESS 51 Franklin St. Annapolis, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Feb 25, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD		25a. DATE REC'D. BY REGISTRAR FEB 26 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson Pendell	
(VRA 15, 4)					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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EST

1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
				GEORGE	HOWARD	SCHOFSTAL	FEBRUARY 15, 1985				625 AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Male		White		June 30, 1906			78 YRS								
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY]		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.								
Pennsylvania		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		EDUCATOR (RET)			A.A. CO.								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 423 Benfield Rd. 21146							
13a. STATE MD	13b. COUNTY A.A.	13c. CITY OR TOWN SEVERNA PARK													
14. FATHER'S NAME FIRST CHARLES				15. MOTHER'S MAIDEN NAME FIRST BLANCHE				MIDDLE LAST BEATTY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT GRACE V. SCHOFSTAL (WIFE)				ADDRESS SAME AS 13							
18. CAUSE OF DEATH (Enter only one cause per line for item 18) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF { (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18 Pneumonia															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET				CITY OR TOWN COUNTY STATE							
22a. I certify that in this hospital I attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.															
22b. SIGNATURE Jorge Ramirez		22c. DEGREE MD				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 7845 OAKWOOD ROAD SUITE 205 GLEN BURNIE, MARYLAND 21061				22f. DATE SIGNED 2/15/85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE FEB. 19, 1985		23c. NAME OF CEMETERY OR CREMATORIAL MOUNT PEACE CEMETERY				23d. LOCATION CITY OR TOWN Minersville				23e. COUNTY STATE PA			
24. FUNERAL DIRECTOR NAME SINGLETON		ADDRESS SINGLETON FUNERAL HOME GLEN BURNIE, MD 21061				25a. DATE REC'D. BY REGISTRAR FEB 19 1985		25b. REGISTRAR'S SIGNATURE J. Wilson Pendell				+			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death, page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transe permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 (showing any injury, or other traumatic event), the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. EST
1 - FOR STATE REGISTRAR			I. DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
NOELINE EVELYN SCOTT						FEBRUARY 09, 1985			0449 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 8 DAY 13 YEAR 1914			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Vermont		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION Office Clerk			12b. KIND OF BUSINESS OR INDUSTRY Dept. Store					
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Brunswick			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 70 Wenner Drive		
14. FATHER'S NAME Verne				15. MOTHER'S MAIDEN NAME Evelyn						LAST Page		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No -----		17. INFORMANT Joan Hamilton			18. ADDRESS 39 Uncas Drive					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 11/10/85 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i> 4 yrs.												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Precipitate myocardial infarction</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Sept. 18 1984 to Feb. 01 1985, that (I) (we) last saw the deceased alive above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>Albert Crollman MD</i>		22c. DEGREE			22d. ADDRESS 1106 SPRING STREET			22e. MEDICAL STAFF ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED 2/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT CROLLMAN					SILVER SPRING, MARYLAND 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-15-85		23c. NAME OF CEMETERY OR CREMATORIAL Center Cemetery			23d. LOCATION CITY OR TOWN Buckland			23e. COUNTY STATE Franklin, Mass.		
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service		ADDRESS Reisterstown, Md.			25a. DATE REC'D. BY REGISTRAR FEB 13 1985			25b. REGISTRAR'S SIGNATURE <i>Franklin Pendall</i>				

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## CONTINUATION

notified no. 208 -

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

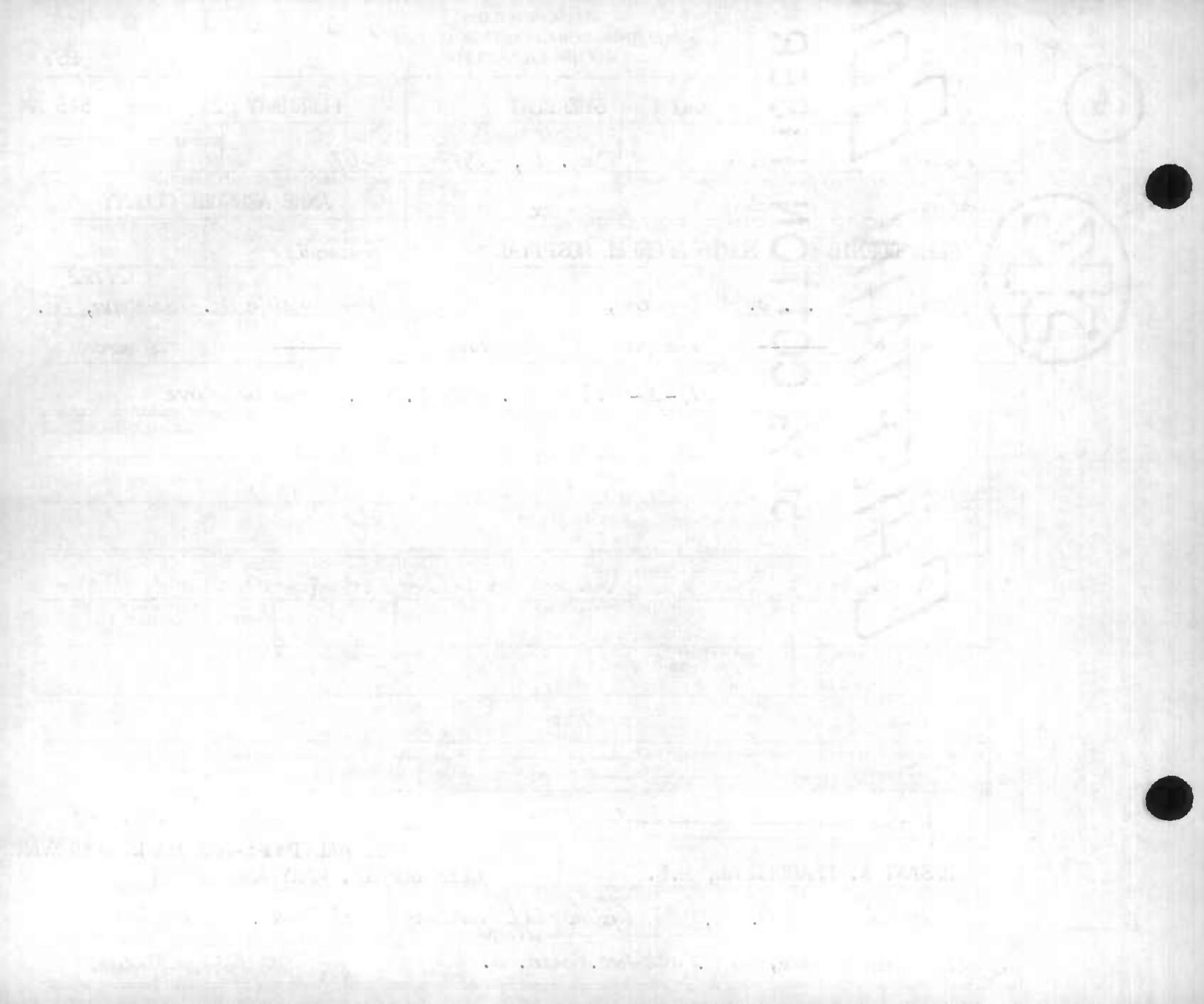
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
				ETHEL	NAOMI	SHERBERT	FEBRUARY 21, 1985				545 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR	
Female		White		Month Day Year Aug. 17, 1917			67 YRS.				IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.			9. BALTIMORE CITY OR COUNTY OF DEATH				MONTHS DAYS HOURS MIN.	
Maryland		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL					Housewife					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		A.A.C.O.		Pasadena,			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8164 Bayside Dr. Pasadena, Md. 21122			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS				
		George	-----	Phelps	Anna			Mrs. Doris L. Dorr, Same as above				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)												
16b. SOCIAL SECURITY NO. 217-26-4813 17. INFORMANT												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF { (b) Severe congestive heart failure												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Diabetes, Ischemic heart disease, Peripheral vascular disease												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>[Signature]</i> DEGREE <i>[Degree]</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 7422 BALTIMORE-ANNAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061										
BASANT K. KHANDELWAL, M.D.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 25, 1985		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>			23d. LOCATION Baltimore, Maryland					
24. FUNERAL DIRECTOR McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.				25a. DATE REC'D. BY REGISTRAR FEB 25 1985			25b. REGISTRAR'S SIGNATURE <i>Jean Davidson Pendell</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours of the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filled in by the funeral director, page 4 may be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours of the death.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical certification section must be completed.



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**MEDICAL CERTIFICATION**
**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

0 3 4 8 5

REG. NO.

1- STATE REGISTRAR		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2b. HOUR														
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		2d. HOUR			
THOMAS SHOUTZ								XXXXXX			2 1 1985		1:35 AM			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS		8. IF UNDER 24 HRS. DAYS		9. BALTIMORE CITY OR COUNTY OF DEATH								
male	negro	Dec. 27, 1984	YRS.	1	4	HOURS	MIN.	Anne Arundel County								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore Md		USA			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Fort George G. Meade		Hambrrough Army Hospital			none		none	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS								
Maryland		A A		Severn		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8248 Deerfield Circle 21144								
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
Tyree				Biffle		Roberta		NO		none		Roberta Shoutz same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost</u> . (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														TITLE (SPECIFY) M.D. <u>Assistant</u> MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)														DATE SIGNED <u>2-1-85</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>Cremation</u> Feb. 5, 1985		23c. NAME OF CEMETERY OR CREMATORIAL <u>Westview Memorial Park</u>		23d. LOCATION CITY OR TOWN <u>Catonsville, Md</u>		COUNTY		STATE						
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
Donaldson Funeral Home, Laurel, Md				FEB 11 1985		Signature										
DHMH - 17 (VR A15 ME (5))																

REBILATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked

#### MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8503480	
1. DECEASED NAME (TYPE OR PRINT) <b>Johnnie O. Slaine</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>February 20, 1985</b>				2b. HOUR <b>6:30 pm</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 14, 1912</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>72 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b>				
10. CITY OR TOWN OF DEATH <b>Millersville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8237 Chalet Ct.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired-Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Millersville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8237 Chalet Ct. 21108</b>			
14. FATHER'S NAME FIRST <b>John</b>		MIDDLE <b>O'Neal</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Martha</b>		MIDDLE <b>Overstreet</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>262-60-2718</b>		17. INFORMANT <b>Nancy Scanlon same as 13</b>		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF LUNG</b>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I, the physician) attended the deceased from <b>JANUARY 8, 1985</b> , to <b>FEBRUARY 20, 1985</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>FEBRUARY 13, 1985</b> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.											
22b. SIGNATURE <b>Dave Rose</b> DEGREE											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dave Rose</b>		22e. ADDRESS <b>653 Old Mill Road Millersville</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED <b>2/20/85</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>25 Feb. 85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Our Lady of the Fields</b>		23d. LOCATION CITY OR TOWN <b>Millersville</b>		COUNTY <b>A.A.</b>		STATE <b>MD.</b>	
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley Glen Burnie MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 22 1985</b>				25b. REGISTRAR'S SIGNATURE					
DHMH - 16 50M 4/83 (VRA 15, 4)											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

items 15, 23c, film#G601- FOR 3-4-85j1b 1 - STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						0 3 4 8 7				
REG. NO. EST													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
ALONIA			MACK		SMITH	FEBRUARY 27, 1985					3:20 P.M.		
3. SEX			4. RACE		5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
Male			Black		12	25	91	93 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
N. Carolina			U.S.A.				ANNE ARUNDEL COUNTY						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE			NORTH ARUNDEL HOSPITAL						Agriculture			State of Md.	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland			A.A.		Severn	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			612 Jones Road 21144				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			Chavis Smith					
Edgar				Smith	Pearl Vasti								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. PERSON TO WHOM APPROPRIATE Penshawkins New Jersey			Paul Smith 7335 Romeo Avenue					
No			240-26-0361										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			Acute Respiratory Failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia						4 days				
			DUE TO, OR AS A CONSEQUENCE OF (c)						4 days				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
Dehydration													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 2-27-85 to 2-27-85, that (I) (we) last saw the deceased alive on 2-27-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.													
22b. SIGNATURE			DEGREE M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	DATE SIGNED 2-27-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						7845 OAKWOOD ROAD, #104 GLEN BURNIE, MARYLAND 21061				
LONG S. HSU, M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. MT.	Auburn	23d. LOCATION							
Burial			3/4/85	MT.	Olivet Cemetery	Baltimore	CITY	STATE					
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR REGISTRATION NUMBER AND SIGNATURE				
Raymond C. Fink			Glen Burnie, Md 21061						MAR 1 1985 Julia Davidson-Randall				
DHMH - 16 60M 7/84 (VRA 15, 4)													

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que no se ha podido dar el resultado de la prueba

que se ha hecho en la otra muestra

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 20 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										EST					
										REG. NO.					
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 908 PM				
		ELIZABETH Magdalene Smith						FEBRUARY 17, 1985			M				
3. SEX		4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female		White			Dec. 19, 1901			83 YRS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY			MD.				
Maryland		U.S.A.													
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT RESIDENCE, GIVE ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
		NORTH ARUNDEL HOSPITAL						Reg. Nurse			Hospital				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3 Idlewood Street 21061						
14. FATHER'S NAME George		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME Mary			MIDDLE			LAST Fair			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. ADDRESS			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Yes		W.W. II		235.28.0448			Zita Somerville (Sister) Same as 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Bente myocardial infarction					
DUE TO, OR AS A CONSEQUENCE OF (b)															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)															
DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE  CHARLES J. WU, M.D.										22c. DATE SIGNED Feb. 19, 1985					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 204, GLEN BURNIE, MARYLAND 21061													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Feb 21, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem Park			23d. LOCATION CITY OR TOWN Glen Burnie			23e. DATE REC'D. BY REGISTRAR FEB 19 1985				
24. FUNERAL DIRECTOR Singleton Funeral Home, Glen Burnie, Md		ADDRESS									25b. REGISTRAR'S SIGNATURE L. Rendell				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

### MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												0 3 4 8 9 EST							
1 - STATE REGISTRAR			REG. NO.																
I. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
ESTHER			LEONA		SMITH		FEBRUARY 27, 1985			400 PM									
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS						
Female			W White		MONTH October		DAY 2		YEAR 1909		75			MONTHS YRS.		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			USA		8					ANNE ARUNDEL COUNTY									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY												
GLEN BURNIE			NORTH ARUNDEL HOSPITAL		12a. Homemaker		12b. Own Home												
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13e. STREET ADDRESS / ZIP CODE 21061 7850 Americana Circle, Apt. 104							
13a. STATE Md.		13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21061 7850 Americana Circle, Apt. 104											
14. FATHER'S NAME FIRST Alvin			MIDDLE Acree		LAST		15. MOTHER'S MAIDEN NAME FIRST Frances			MIDDLE		LAST Chaney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT		17. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
No			219-05-8713		Dolores Kairos, same as 13														
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																			
(b) DUE TO, OR AS A CONSEQUENCE OF <i>Hypertension</i>																			
(c) DUE TO, OR AS A CONSEQUENCE OF <i></i>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>21/27/85</i> , 19 <i>85</i> , to <i>21/27/85</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>21/27/85</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
THE PHYSICIAN'S NAME (TYPE OR PRINT) <i>George B. Ramirez, M.D.</i>												22c. DATE SIGNED <i>2/27/85</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 2 March 85		23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Memorial		23d. LOCATION CITY OR TOWN Glen Burnie			COUNTY AA		STATE Md.							
24. FUNERAL DIRECTOR NAME <i>James S. Kirkley, Glen Burnie, Md.</i>												25a. DATE REC'D. BY REGISTRAR MAR 1 1985							
ADDRESS <i>J. Kirkley, Glen Burnie, Md.</i>												25b. REGISTRAR'S SIGNATURE <i>Linda Garrison-Randall</i>							



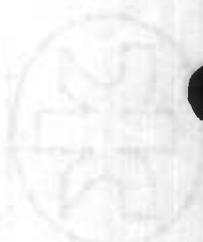
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 5 and 6 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

1. DECEASED NAME				FIRST ANNA	MIDDLE ---	LAST SIPELGAS	2d. DATE OF DEATH FEBRUARY 27 1985	MONTH 27	DAY 1985	YEAR 245 PM	2b. HOUR 245 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH Month April Day 7, 1913 Year	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	7. IF UNDER 1 YEAR MONTHS 0	8. IF UNDER 24 HRS DAYS 0						
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia	10. CITY OR TOWN OF DEATH GLEN BURNIE	11. CITIZEN OF WHAT COUNTRY? U.S.A.	12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NORTH ARUNDEL HOSPITAL	13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 303 Dorchester Road 21122	12d. USUAL OCCUPATION Housewife	12e. KIND OF BUSINESS OR INDUSTRY Own Home	
14. FATHER'S NAME FIRST (unknown)	MIDDLE ---	LAST Mueller	15. MOTHER'S MAIDEN NAME FIRST (unknown)	MIDDLE ---	LAST ---						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO 220-30-0200	17. INFORMANT Mr. Sergei Sipelgas	ADDRESS Pasadena, Md. 303 Dorchester Road 21122								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Caduc Auct</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>one month to two months</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i> ; <i>Bowel obstr w/ ischemia</i>											
(c) <i>Marrow Carcinomatosis</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Over pronounced edema by Dr. Morkov</i>											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) ---									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Rosoff</i>						DEGREE	22c. DATE SIGNED <i>3/2/85</i>				
22d. PHYSICIAN'S NAME (TYPE) <i>PAUL M. ROSOFF</i>						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 3/2/85	23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Park	23d. LOCATION Glen Burnie	23e. ADDRESS 1575-425 RITCHIE HIGHWAY, S.E. GLEN BURNIE, MARYLAND 21061	COUNTY Anne Arundel	STATE Md.
24. FUNERAL DIRECTOR NAME Mc Cully Funeral Home of Pasadena Mountain & Tick Neck Rds. Pasadena, Md. 21122						25a. DATE REC'D. BY REGISTRATION UNIT MAR 1 1985	25b. SIGNATURE <i>John J. McCully</i>				

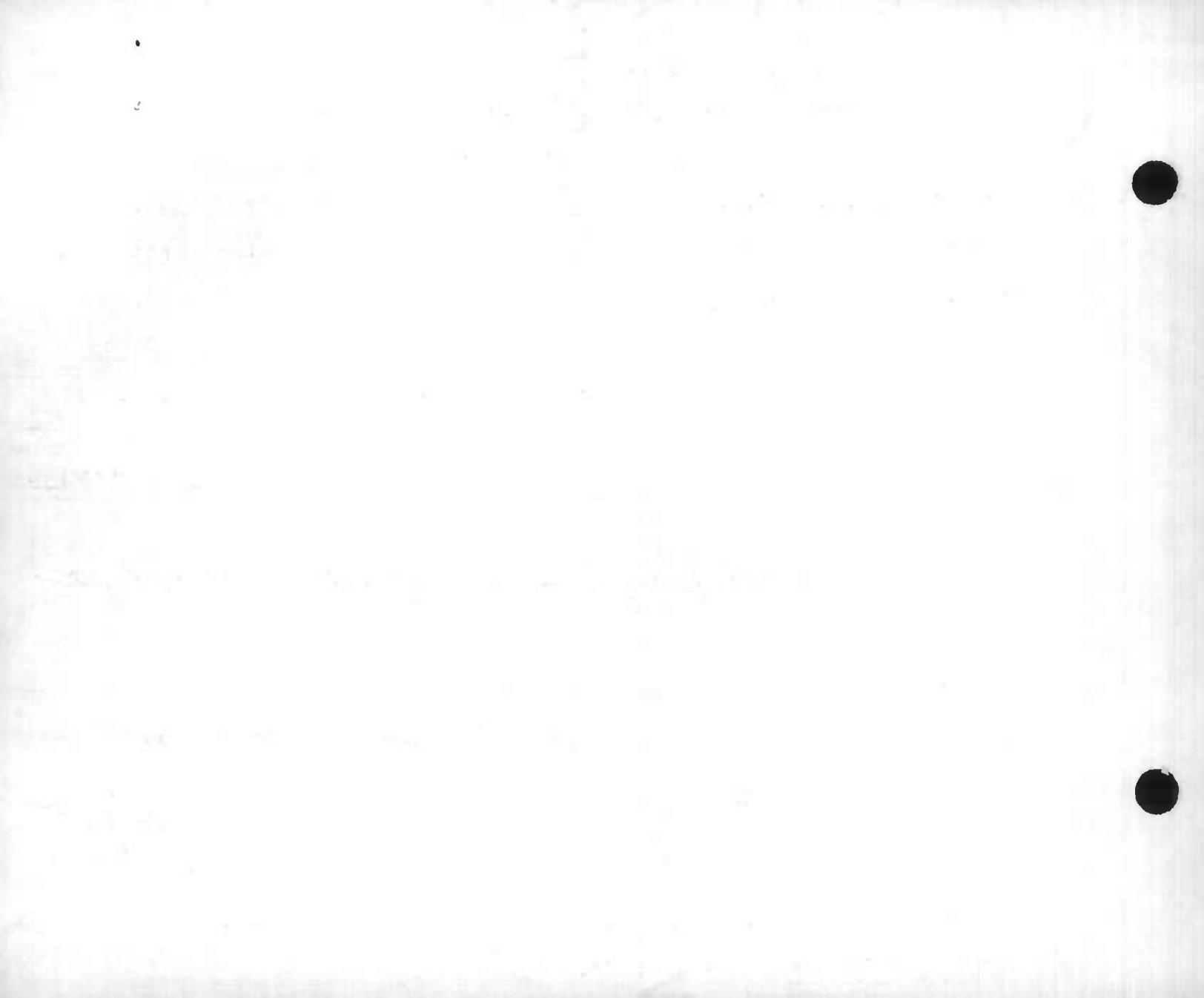


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial-transit point. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 03491	
1 - FOR STATE REGISTRAR			I. DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Franklin P. Stanbro						Feb. 11, 1985							
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS			IF UNDER 1 YEAR IF UNDER 24 HRS			
				Sept. 17, 1910			74			YRS. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unidilla, N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.						
10. CITY OR TOWN OF DEATH Harwood		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brashears Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) estimator			12b. KIND OF BUSINESS OR INDUSTRY steel					
13a. STATE Md.		13b. COUNTY MONT.		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3507 Kayson St. 20706				
14. FATHER'S NAME FIRST Frank		MIDDLE Stanbro		LAST		15. MOTHER'S MAIDEN NAME FIRST Effie			MIDDLE LAST Place				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. ---			17. INFORMANT			ADDRESS 545 Epping Forest Rd.					
					Franklin K. Stanbro			Ann.Md. 21401					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Marasmus												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)													
DUE TO, OR AS A CONSEQUENCE OF (c) Alzheimer's disease - 3 years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Narcolepsy Rx Dexedrine most of life													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 12-23-84 to 8-13-84, that (I) (we) last saw the deceased alive on 19-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE E.W. Lott M.D. DEGREE													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E.W. Lott M.D.		22e. ADDRESS Davidsorville, Md.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/12/85					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/14/85		23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cem.			23d. LOCATION CITY OR TOWN Wash. D.C. COUNTY STATE						
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home Ann. Md. 21401		ADDRESS 12 Ridgely Ave.			25a. DATE REC'D. BY REGISTRAR FEB 14 1985			25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do so.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 45 03492							
1 - STATE REGISTRAR				2d. DATE OF DEATH MONTH DAY YEAR								2d. HOUR							
I. DECEDENT'S NAME (TYPE OR PRINT)				FIRST		MIDDLE		STIVARIUS		STIVARIUS		Feb 21 85		145 PM					
3. SEX				RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS					
FEMALE				CAUC		6-20-12		72 YRS.				MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
WISCONSIN				U.S.A.				A.A.				A.A.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
ANNAPOLIS				A.A.B.H.								RET.				JOURNALIST			
13a. STATE MD.				13b. COUNTY A.A.		13c. CITY OR TOWN SEVERNA PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 221 NEWPORT DR. 21146				2114					
14. FATHER'S NAME FIRST (UNKNOWN)				MIDDLE MORSE		LAST IDA		15. MOTHER'S MAIDEN NAME BAXTER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 387-32-3844				17. INFORMANT ADDRESS, JANET Smolinski (same as 13)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours							
NO																			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY:				IMMEDIATE CAUSE (a) Respiratory Failure															
				DUE TO, OR AS A CONSEQUENCE OF (b) Stroke								Hours							
				DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular disease								Years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Pulmonary Edema, Emphysema																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART II)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 84 to Feb 21 19 85, to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Robert Kocher				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 2/21/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT KOCHER				22e. ADDRESS 269 Peninsula Farm Road Arnold MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIES) CREMATION				23b. DATE FEB. 22, 1985				23c. NAME OF CEMETERY OR CREMATORIAL WESTVIEW Crematory				23d. LOCATION CITY OR TOWN WESTVIEW BALTIMORE MD							
24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME				501. RITCHIE Hwy. SEVERNA PARK, MD.				25a. DATE REC'D. BY REGISTRAR FEB 26 1985				25b. REGISTRAR'S SIGNATURE John Davidson							
BP _____																			
DHMH - 16 60M 7/84 (VRA 15. 4)																			

4. 1991. 10. 25.

2000. 10. 25.

2000. 10. 25.

(2000. 10. 25.)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filed in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5 0 3 4 9 3				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Addie			Frances		Syme			February 25, 1985					M	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White		Month Day Year Jan. 24, 1914			71		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		YRS.				
Alabama			USA					Anne Arundel County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Glen Burnie			North Arundel Hospital		Housewife			Domestic						
13. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Maryland			Anne Arundel		Pasadena			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		192 Irene Drive		21122		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST		MIDDLE	LAST		
Allen					Mashburn	Viola								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS				
no					218-26-7858			James C. Syme Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										2 hrs				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery Disease</i>										6 yrs				
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-5-85 to 2-27-85, and that (I) (we) last saw the deceased alive on 2-5-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										2-27-85				
22b. SIGNATURE										22c. DEGREE				
REEDMAN										ATTENDING PHYSICIAN	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS				
MD REEDMAN										5400 Old Court Rd				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial			2/27/1985		Glen Haven Mem. Pk.			Glen Burnie, A.A. Co., Md.						
24. FUNERAL DIRECTOR NAME			Balto., Md., 21225					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
McCullum Funeral Homes			237 E. Patapsco Ave.,					1985		John Carlson Pendell				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

RECORDED BY \_\_\_\_\_

ATTENDED BY \_\_\_\_\_

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 03494		
1 - FOR STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Edmund Melvin Thomas						Dec.	25	19	2	1	85	7 <sup>00</sup>	AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			White			MONTH	DAY	YEAR	73	YRS		IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.		
Maryland			U.S.A.			WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Anne Arundel			MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Annapolis			Anne Arundel General Hospital			Retired			Carpenter					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
MD			A.A.			Annapolis			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21461 107 Riverview Avenue		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	ADDRESS		
William F. Thomas						Elizabeth V. Tayman						Same as #13		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IN, NO OR UNKNOWN) (IF YES, GIVE WAR RATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes			214-05-0141			Charlesetta A. Thomas-			Respiratory Failure 20			1 wk		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) Pneumonia and			(c) Congestive Heart Failure						1 wk		
DUE TO, OR AS A CONSEQUENCE OF												Months		
DUE TO, OR AS A CONSEQUENCE OF														
DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.			Severe Emphysema			Atherosclerosis			Renal Failure					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION STREET			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1/26 1985 to 2/1 1985, that (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.			22b. SIGNATURE Joseph N. Friend M.D.			22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 2/1/85					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph N. Friend			22f. ADDRESS 205 Ridgeley Ave Annapolis, MD			22g. ADDRESS			22h. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 4, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Maryland Veteran			23d. LOCATION Crownsville			23e. COUNTY STATE		
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD			25a. DATE REC'D. BY REGISTRAR EEB 8 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Fordell								
BP _____														
DHMH - 16 60M 7/84 (VRA 15, 4)														

1000 ft. elevation, and by the 28th had  
arrived at the old camp site.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 03495				
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			Marie L. Thomas						Feb. 5, 1985						M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White			Month Day Year Feb. 28, 1902			82			MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Anne Arundel				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis			Anne Arundel General Hospital Res. Dept. of Army Civil Service													
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
MD			A.A.			Riva						16 Elm Road 21140				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. ADDRESS						O'Donovan				
George H. Bliss, Sr.			Maude			533 Bay View Point Dr.						Edgewater, MD 21637				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO			518-32-5201			Marie S. Leinbach			CARDIAC ARREST			--				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			b) DUE TO, OR AS A CONSEQUENCE OF Acute Myocardial Infarction @ 2 hrs			c) DUE TO, OR AS A CONSEQUENCE OF Hypertensive Cardiovascular ds. 30 yrs										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>Jan 15, 1983</u> to <u>Jan 15, 1985</u> , that (I) (we) last saw the deceased alive on <u>Jan 15, 1983</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
23a. SIGNATURE			23b. DEGREE			23c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			23d. DATE SIGNED							
LEMOND W. COTT.									Feb. 8, 1985							
23e. PHYSICIAN'S NAME (TYPE OR PRINT)			23f. ADDRESS			23g. LOCATION CITY OR TOWN			23h. COUNTY			STATE				
LEYMOND W. COTT.			DAVISONVILLE MO 21035			Annapolis A.A. MD										
23a. BURIAL, CREMATION, REMOVAL (TYPE)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE	
Burial			Feb. 8, 1985			Hillcrest			Annapolis			FEB 8 1985			John Davidson-Gandell	
24. FUNERAL DIRECTOR NAME			ADDRESS													
Taylor Funeral Chapel-Annapolis, MD 21401																
DHMH - 16 50M 4/B3 (VRA 15, 4)																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be retained for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT:

If Item 21 is marked or if Item 18 shows any injury, or other traumatic event the medical examiner shall be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 03496		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
PEARL			L.	Thomas		2 14 85			6:40 AM					
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			
FEMALE			CAUCASIAN		JULY 22 1913			71			MONTHS DAYS			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
PENNSYLVANIA			UNITED STATES					ANNE ARUNDEL						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
PASDENA			8243 BALT. ANNAPOLIS BLVD.		Homemaker			HOME						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												21122		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			
MARYLAND			ANNE ARUNDEL		PASDENA			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			8243 BALT. ANNAP. BLVD.			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST			MIDDLE	LAST	
THOMAS			F.	GARRETTSON		ESTHER			V.			MILLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			8245 BALT. ANNA. BLVD.			
NO			—		216-92-2817			EDWARD D. THOMAS, JR.			PASDENA, MD			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ Metastatic Carcinoma to Vagina														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertension, Diabetes mellitus														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
Oct 1, 1984			Urinary retention			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (the hospital) attended the deceased from 5-15 1975 to 2-14 1985, that (I) (was) lost soul the deceased alive on 2-9 1985, and that in (my) (opinion) death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.												22c. DATE SIGNED 2-14-85		
22b. SIGNATURE A BRADLEY DAUGHRATHY MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A BRADLEY DAUGHRATHY			22e. ADDRESS			ARBUTUS, MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE FEB 16, 1985			23c. NAME OF CEMETERY OR CREMATORIAL MEADOWRIDGE CEMETERY			23d. LOCATION DORSEY			COUNTY	STATE	
24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR FEB 20 1985			25b. REGISTRAR'S SIGNATURE Julia L. Wilson-Pendleton								

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A



СОВЕТСКОЙ РАБОЧЕЙ

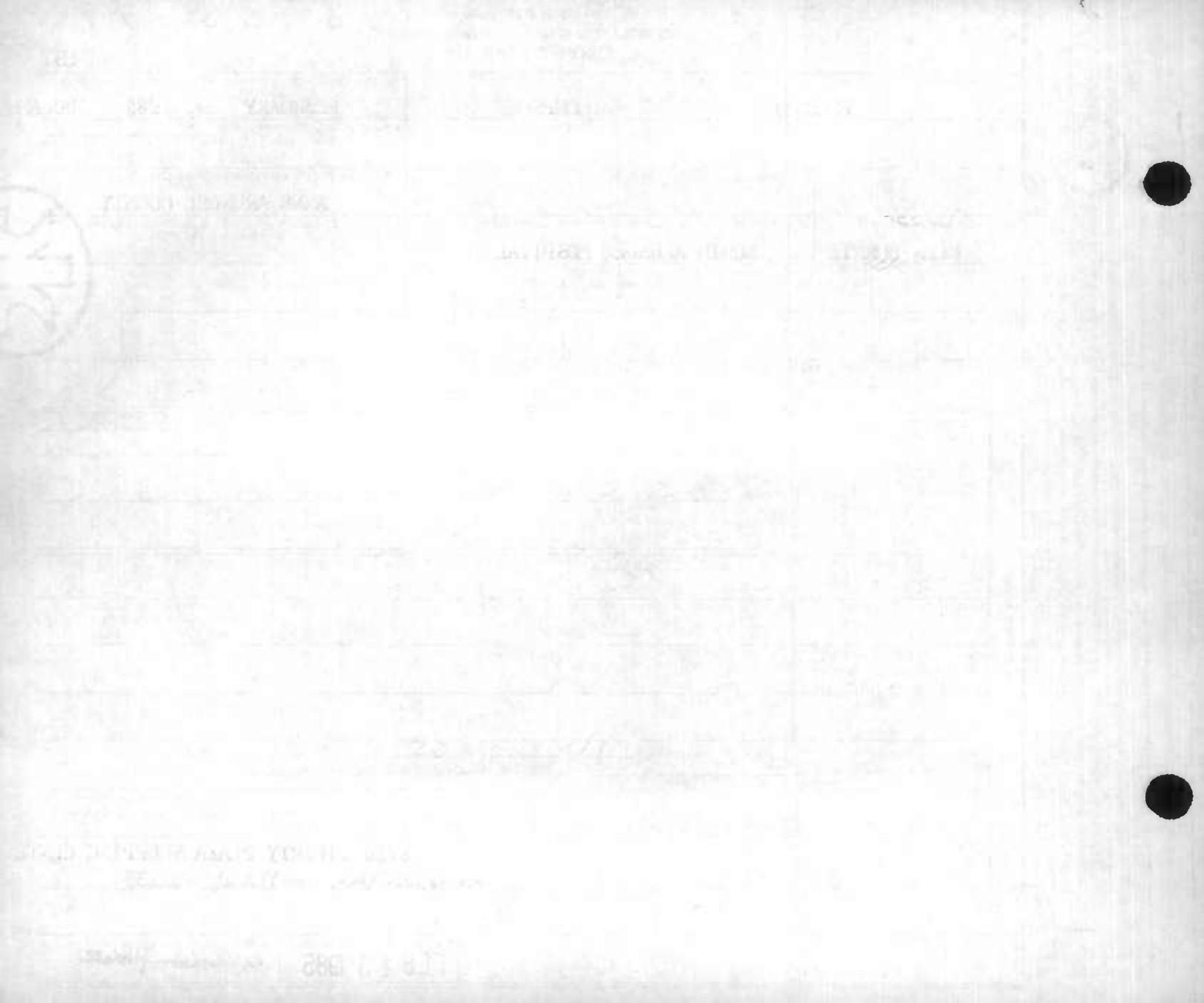
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Age 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

SCIENCE 3503497

EST

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
FLOSSIE O. THOMPSON							FEBRUARY	9, 1985	100 M.A.M.			
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Black	MONTH	DAY	YEAR	80	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					
N. Carolina		U.S.A.					ANNE ARUNDEL COUNTY MD.					
11. CITY OR TOWN OF DEATH		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
GLEN BURNIE		NORTH ARUNDEL HOSPITAL										
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13e. STREET ADDRESS / ZIP CODE						
14. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		2011 Penrose Street 21223						
Maryland		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
4. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST			
Giles			G.		Majette	Julia			Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Unknown			820-01-3209			Brownie Thompson			2011 Penrose Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Caduveo</i> <i>Endocarditis</i> } DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardiomyopathy</i>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Diabetes</i> , <i>on oxygen</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
		P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> , 19 <u>85</u> , to <u>2/11</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/9</u> , 19 <u>85</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.												
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
<i>Robert Kresowicki MD</i>								<i>2/13/85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			8726 LIBERTY PLAZA SHOPPING CENTER							
<i>Robert Kresowicki MD</i>					RANDALLSTOWN, MARYLAND 21133							
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 2/14/85		23c. NAME OF CEMETERY OR CREMATORIUM Mount Auburn Cem.		23d. LOCATION Baltimore		CITY/TOWN		COUNTY	STATE	
24. FUNERAL DIRECTOR <i>Name</i> Wm C March F/H Inc.		ADDRESS 1101 E North Ave.		25a. DATE REC'D. BY REGISTRAR FEB 13 1985		25b. REGISTRAR'S SIGNATURE <i>Laura Davidson-Pendleton</i>						

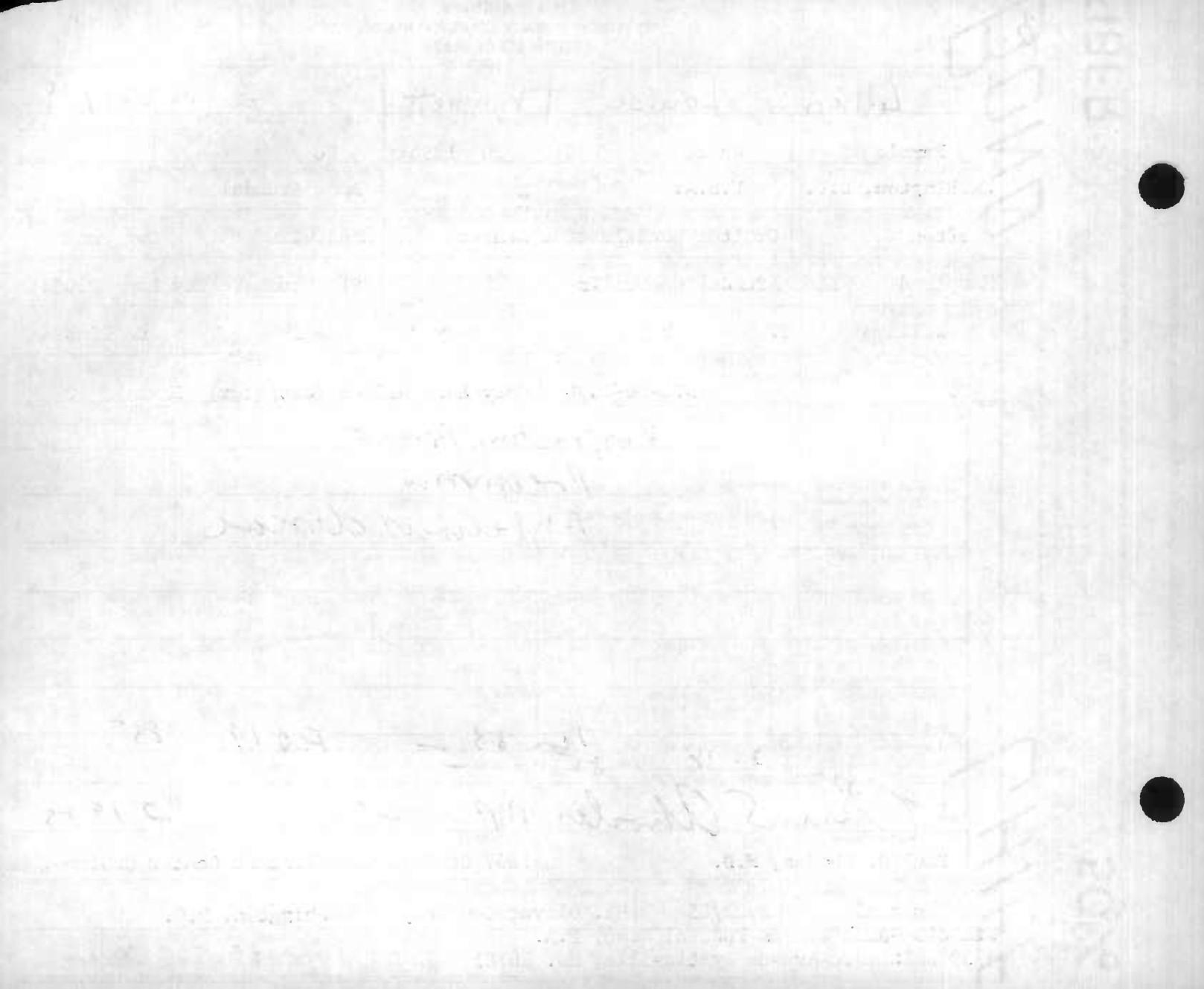


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.  
 WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03498
1 - FOR STATE REGISTRAR				
1. DECEASED NAME (TYPE OR PRINT)		LAST		2a. DATE OF DEATH MONTH DAY YEAR
Lillian Louise Thorbett		8 20 1896		2 19 85
2b. HOUR 1:00 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 20 1896
6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				
10. CITY OR TOWN OF DEATH Crofton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Crofton Convalescent Center		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		12b. USUAL OCCUPATION Housewife		
13a. STATE Anne Arundel		13b. CITY OR TOWN Gambrills		
14. FATHER'S NAME William		15. MOTHER'S MAIDEN NAME Mary Anne Collins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 578-36-1698		
17. INFORMANT Mary Anne Miller (Daughter)		ADDRESS Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia				
DUE TO, OR AS A CONSEQUENCE OF (c) Alzheimer's disease				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from Jan 85 to Feb 19 1985, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Paul S. Rhodes, M.D.		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22d. ADDRESS 1667 Crofton Convalescent Center Crofton, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/22/85		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery
23d. LOCATION CITY OR TOWN Washington, D.C.		23e. COUNTY STATE		
24. FUNERAL DIRECTOR'S NAME Graech's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				
25a. DATE REC'D. BY REGISTRAR FFB 21 1985		25b. REGISTRAR'S SIGNATURE Julie Davidson Rendell		



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 03499

FOR  
STATE  
REGISTRAR

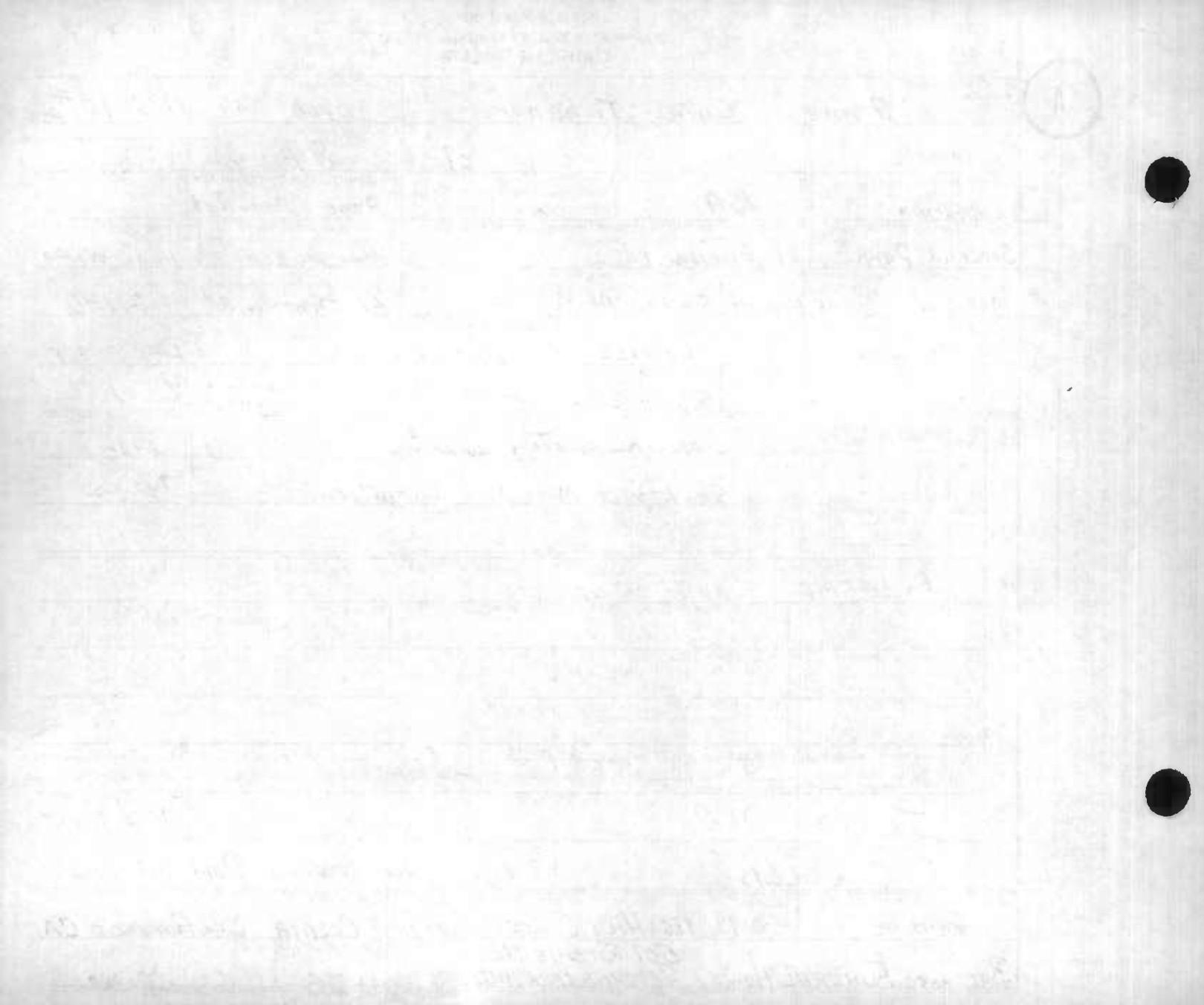
REG. NO.

1. DECEASED NAME: FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Anne Carroll Tichenor			Feb 14 1985	10:30 PM
1c. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	
Female	CAUC	MONTH 08 DAY 16 YEAR 01	84	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY	7b. CITIZEN OF WHAT COUNTRY?	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
Severna Park	USA			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Severna Park	21 Emerson Rd			Home maker
13. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 21 Emerson Rd 21146
Maryland	Anne Arundel	Severna Park		
14. FATHER'S NAME	FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME	LAST	
Jeremiah	Carroll	Hannah	Dempsey	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	
NO	568-10-3122	Suzanne Tichenor	21 Emerson Rd Severna Park Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Upper respiratory infection</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24hr				
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sensitivity + MARKed Inanition</u> 7 years				
DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <u>Fx Left Hip</u> <u>Severe osteoporosis</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (the hospital) attended the deceased from <u>Sep 16 1982</u> to <u>Feb 19 1985</u> , that (I) (we) last saw the deceased alive on <u>Jan 16 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>T.C. Cullis MD</u>			DEGREE	22c. DATE SIGNED <u>15 Feb 85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>T. C. CULLIS</u>	22e. ADDRESS <u>7-Riggs Ave Severna Park Md. 21146</u>			
23a. BURIAL, CREMATION, REMOVAL SPECIMEN	23b. DATE <u>Burial</u> <u>FEB. 19, 1985</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Holy Cross Cemetery</u>	23d. LOCATION CITY OR TOWN <u>Colma</u>	STATE <u>SAN FRANCISCO CA.</u>
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR <u>BARBARA FUNERAL HOME</u>		25b. REGISTRAR'S SIGNATURE <u>20 1985</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please let me be informed by the attending physician and completely filled in by the funeral director prior to being filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Form 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner must be notified.

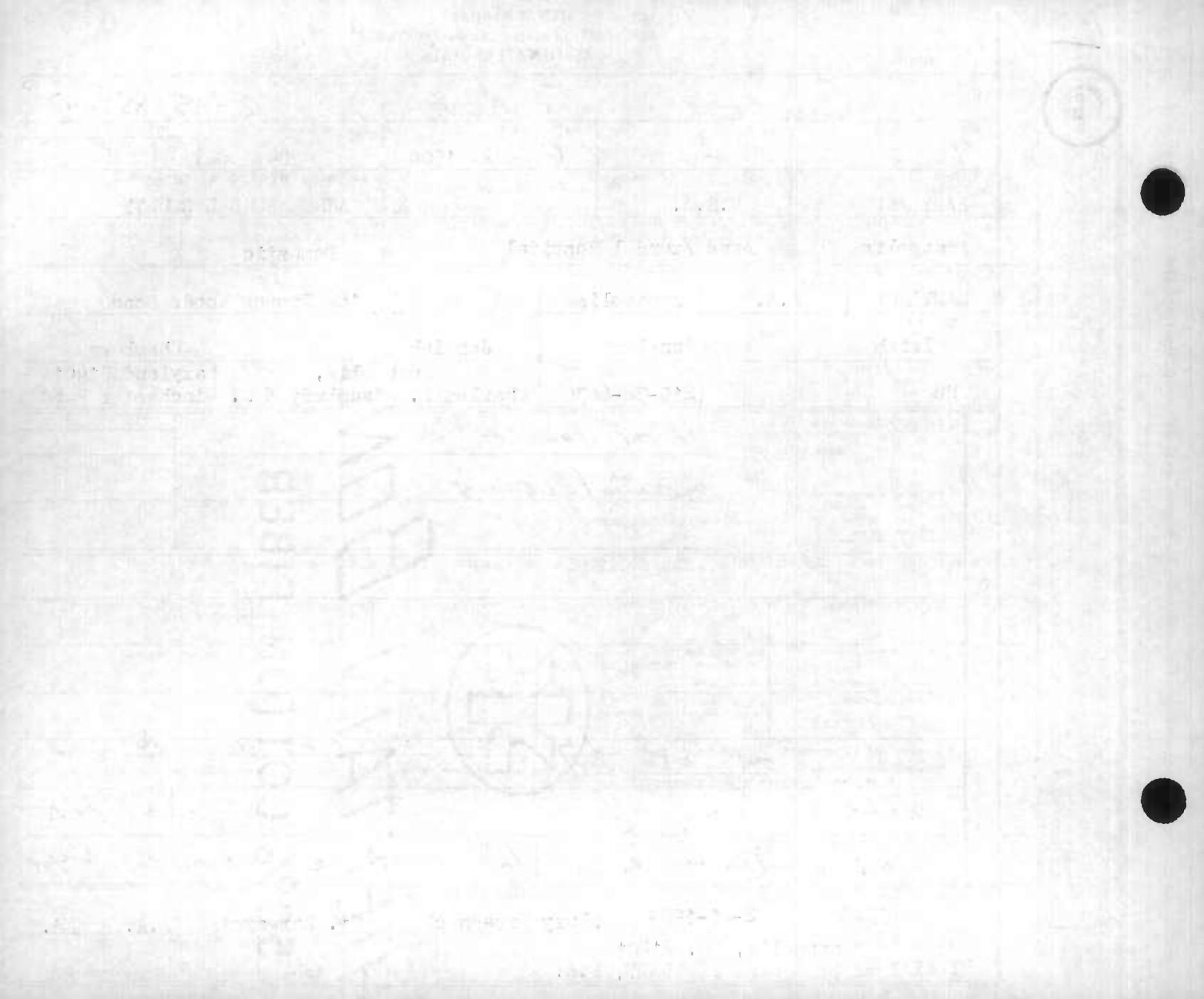


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be rehanded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

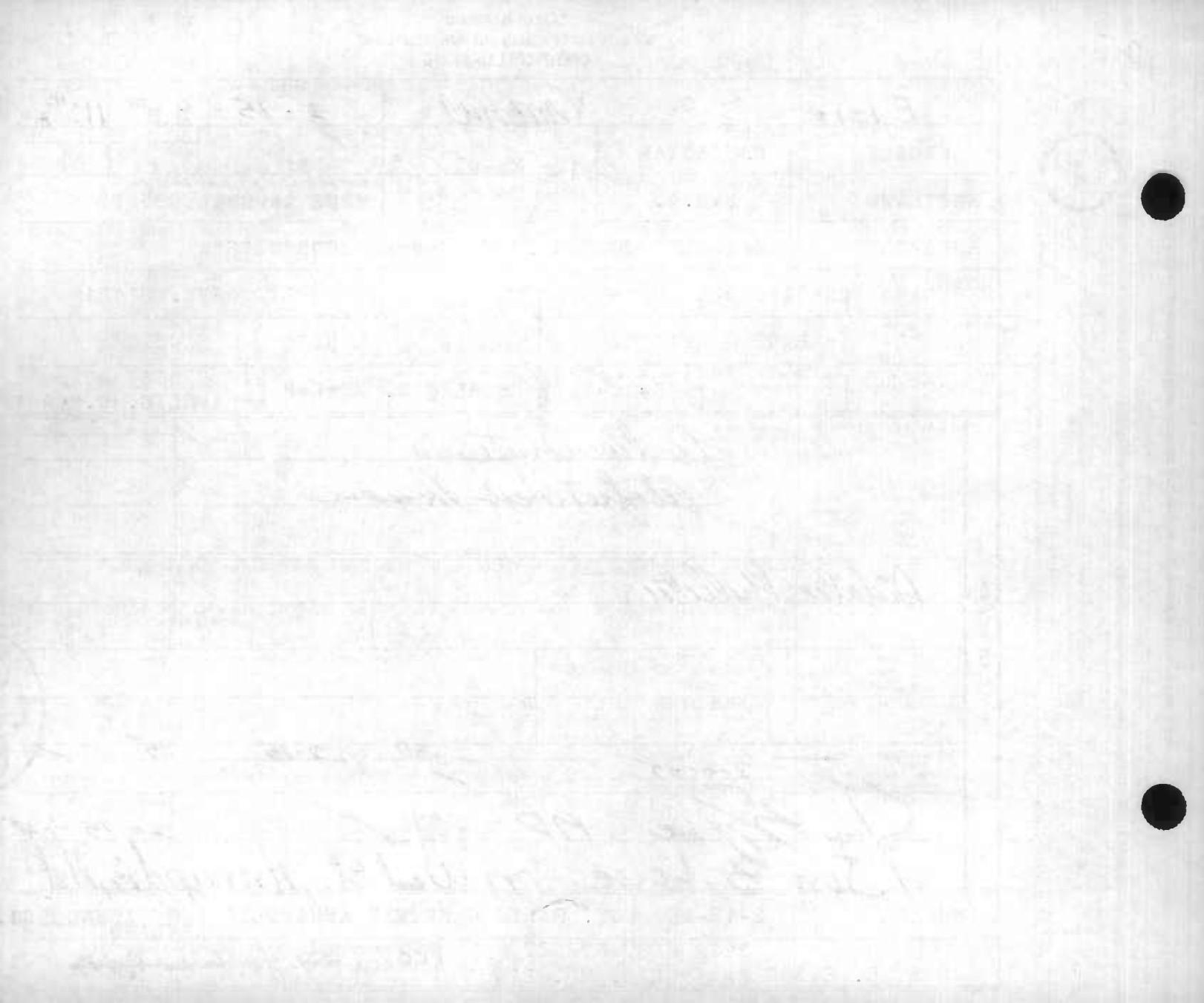
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - FOR STATE REGISTRAR			2d. DATE OF DEATH MONTH DAY YEAR									2d. HOUR P	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST							
Annie						Tucker						2 - 15 - 85	
3 SEX F			4 RACE B			5. DATE OF BIRTH MONTH 6 DAY 2 YEAR 1900			6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY			MD.	
10 CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic			12b. KIND OF BUSINESS OR INDUSTRY				
13 STATE MARYLAND			13b COUNTY A.A.			13c CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 162 Browns Woods Road	
14 FATHER'S NAME FIRST Isiah			MIDDLE			LAST Stansbury			15. MOTHER'S MAIDEN NAME FIRST Jermiah			MIDDLE	
LAST Chambers													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 219-32-6639			17. INFORMANT Annapolis, ADDRESS Maryland 21401 Charles F. Stansbury 5 S. Winchester Road			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure													
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardialclerosis													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (the hospital) attended the deceased from July 9, 1984, to Oct 23, 1984, that (I) (we) last saw the deceased alive on Oct 23, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.												22c. DATE SIGNED 2/18/85	
22b. SIGNATURE David L. Rose, M.D.			DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David L. Rose, M.D.			22e. ADDRESS 1616 Forest St. Annapolis 21403										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2-21-1985			23c. NAME OF CEMETERY OR CREMATORIAL Asbury Broadneck			23d. LOCATION CITY OR TOWN St. Margarets			COUNTY A.A.	STATE Md.
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. ADDRESS												25a. DATE REC'D. BY REGISTRAR FFB 22 1985	25b. REGISTRAR'S SIGNATURE Laurelson-Randall



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 in marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												03501	
1 - FOR STATE REGISTRAR											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	26 HOUR	
Elsie			G.	Vaughn		2-15-85					85	11:45 A.M.	
3. SEX			4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE			CAUCASIAN	MONTH	DAY	YEAR	81	YRS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE STATE OR FOREIGN			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
MARYLAND			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			ANNE ARUNDEL COUNTY				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY				
ANNAPOLIS			ANNAPOLIS CONVALESCENT CENTER			HOUSEWIFE							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE MARYLAND			13c. CITY OR TOWN ANNAPOLIS			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14 STREET ADDRESS 400 MELVIN AVE. 21401				
14. FATHER'S NAME DANIEL			LEE	PADGET	15. MOTHER'S MAIDEN NAME ELSIE			16. ADDRESS CHARLES R. PHELPS 218 GIBSON ROAD ANNAPOLIS, MD. 21401					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)			16b. SOCIAL SECURITY NO 558-26-8379			17. INFORMANT CHARLES R. PHELPS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b and 18c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cordice Brightman</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>Allegremere Brown</i> DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Bethel Muller</i>													
19. MEDICAL CERTIFICATION DATE			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (the hospital) attended the deceased from 1980 to 1985, that (I) (we) last saw the deceased alive on 2-8-85 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.													
22b. SIGNATURE <i>Jon B. Lowe</i>			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 2-15-85				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Jon B. Lowe			22f. ADDRESS 72 West St., Annapolis, Md.										
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 2-18-85			23c. NAME OF CEMETERY OR CREMATORIUM ST. MARYS CEMETERY			23d. LOCATION ANNAPOLIS ANNE ARUNDEL CO. MARYLAND				
24. FUNERAL DIRECTOR NAME ROBERT E. EVANS			ADDRESS 1212 WEST STREET ANNAPOLIS, MD. 21401			FEB 27 1985			RECEIVED FROM DIRECTOR'S REGISTRY'S SIGNATURE <i>Robert E. Evans</i>				



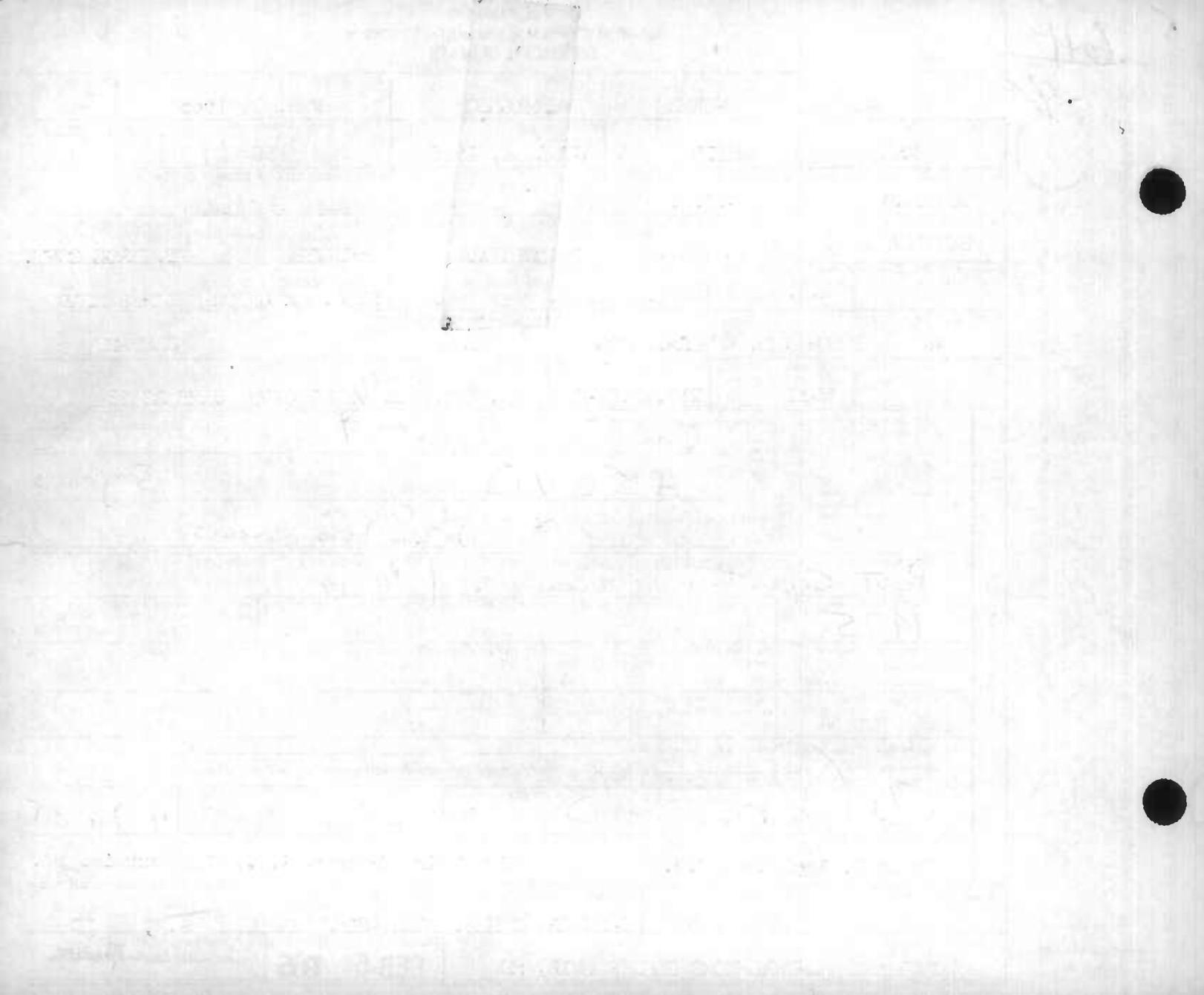
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in one of the following ways:

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5503502				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
RUSSELL			NORMAN		VERMILLION		FEB. 2, 1985							
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE			WHITE		JUNE 4, 1926		58 YRS.			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL, MD.							
10. CITY OR TOWN OF DEATH SEVERNA PARK			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 51 W. EARLEIGH HEIGHTS ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER			12b. KIND OF BUSINESS OR INDUSTRY FT. MEADE GOVT						
13a. STATE MD			13b. COUNTY A.A.		13c. CITY OR TOWN SEVERNA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 51 W. EARLEIGH HEIGHTS ROAD 21146				
14. FATHER'S NAME FIRST JOSEPH			MIDDLE FRANKLIN		LAST VERMILLION		15. MOTHER'S MAIDEN NAME FIRST LEANA			MIDDLE LAST JANUARY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT (WIFE) MRS. HELEN C. VERMILLION			ADDRESS SAME AS 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest *</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>A SCVD</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>* County Coroner Dr. Wm. Jones concurs</i>														
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Post Operative Carcinoma of larynx</i>														
19a. DATE OF OPERATION 1975			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>John Appleton, M.D.</i>										22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James R. Appleton, M.D.										22e. DATE SIGNED 4/7/85				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE FEB. 6, 1985		23c. NAME OF CEMETERY OR CREMATORIAL GLEN HAVEN MEM. PARK		23d. LOCATION CITY OR TOWN GLEN BURNIE			COUNTY A.A.		STATE MD		
24 FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME			ADDRESS GLEN BURNIE, MD		25a. DATE REC'D. BY REGISTRAR FEB 5 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendell						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section of this certificate must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 5 0 3 5 0 3	EST				
										REG. NO.					
1 - FOR STATE REGISTRAR			MIDDLE			LAST				2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
I. DECEASED NAME (TYPE OR PRINT)			RUTH			Eva VONDERHORST				FEBRUARY 11, 1985					0725 PM
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 16, 1928</b>				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY <b>New Jersey</b>			7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stone-attendant</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Stone-bus.</b>					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>			13c. CITY OR TOWN <b>Pasadena</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8452 Garland Rd. / 21122</b>			
14. FATHER'S NAME FIRST <b>Edward</b>			MIDDLE <b>J.</b>			LAST <b>Sawyer</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Jessie</b>		MIDDLE - LAST <b>Healy</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>- - - 135-20-4248</b>			17. INFORMANT <b>Richard W. Vonderhorst/427 Old Riverside Rd. (21125)</b>				ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MI</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>CADx</b>										Years <b>Years</b>					
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterosclerosis</b>										Years <b>Years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>DM, hypertension.</b>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>19</b>			21f. LOCATION STREET <b>581</b>		CITY OR TOWN <b>19 85</b>		COUNTY <b>14</b>		STATE <b>19 85</b>			
22a. I certify that (I) the hospital attended the deceased from now the deceased died on <b>19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not see the body after death.										22b. SIGNATURE <b>David Schwartz</b>					
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID SCHWARTZ</b>			22d. ADDRESS <b>7845 OAKWOOD ROAD GLEN BURNIE MARYLAND 21061</b>			22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED <b>2/14/85</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>2-15-85</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Security Process Inc.</b>				23d. LOCATION CITY OR TOWN <b>Catonsville, Baltimore, Md.</b>		COUNTY <b>Baltimore</b>		STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>McGarry Funeral Home, Pasadena, Maryland</b>			24b. ADDRESS <b>Mountain &amp; Tick Neck Rds.</b>			24c. DATE REC'D. BY REGISTRAR <b>FEB 13 1985</b>				24d. REGISTRAR'S SIGNATURE <b>John R. Wilson</b>		24e. STAMP <b>State of Maryland</b>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE prior to burial, cremation, or removal.  
IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85	03504	EST			
1 - FOR STATE REGISTRAR			REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR					
JOHN		A		WALKER	FEBRUARY		18,	1985		1220 AM					
3. SEX		4 RACE		5. DATE OF BIRTH		MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male		Caucasian		11 17 17		67		YRS	67		MONTHS	DAYS	HOURS	MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
Pennsylvania		U.S.A.													
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL								T.V. Salesman		Sales			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS)										13e. STREET ADDRESS / ZIP CODE					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE							
Maryland		A.A.		Hanover		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1143 Dorsey Road 21076							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME					
FIRST Russell		MIDDLE C.	LAST Walker			FIRST Gertrude		MIDDLE LAST Bittner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
Yes		WW II		174-16-1187		Helen M. Walker 1143 Dorsey Road									
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										years					
{ (b) cerebrovascular disease										months					
{ DUE TO, OR AS A CONSEQUENCE OF (c) recurrent pneumonia															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
dementia		dementia													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
-		-		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) <input checked="" type="checkbox"/> (his hospital) attended the deceased from Feb. 17, 1985, to Feb. 18, 1985, that (I) <input type="checkbox"/> (we) last saw the deceased alive on Feb. 18, 1985, and that in (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.		22b. SIGNATURE Christine A. Marino, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/18/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTINE A. MARINO, M.D.		22e. ADDRESS 8667 FT. SMALLWOOD ROAD PASADENA, MARYLAND 21122													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-21-85		23c. NAME OF CEMETERY OR CREMATORIAL Crownsville Cemetery		23d. LOCATION CITY OR TOWN Crownsville, A.A. Md.									
24. FUNERAL DIRECTOR NAME Raymond C. Fink Glen Burnie, Md. 21061		ADDRESS		25a. DATE REC'D. BY REGISTRAR FEB 20 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson Pendleton									

20150 11 C5 C5 11

1772. 1773. 1774. 1775. 1776. 1777.

10. *U. S. Fish Commission, Report for 1883*, p. 11.

May 5 A.T. 1967



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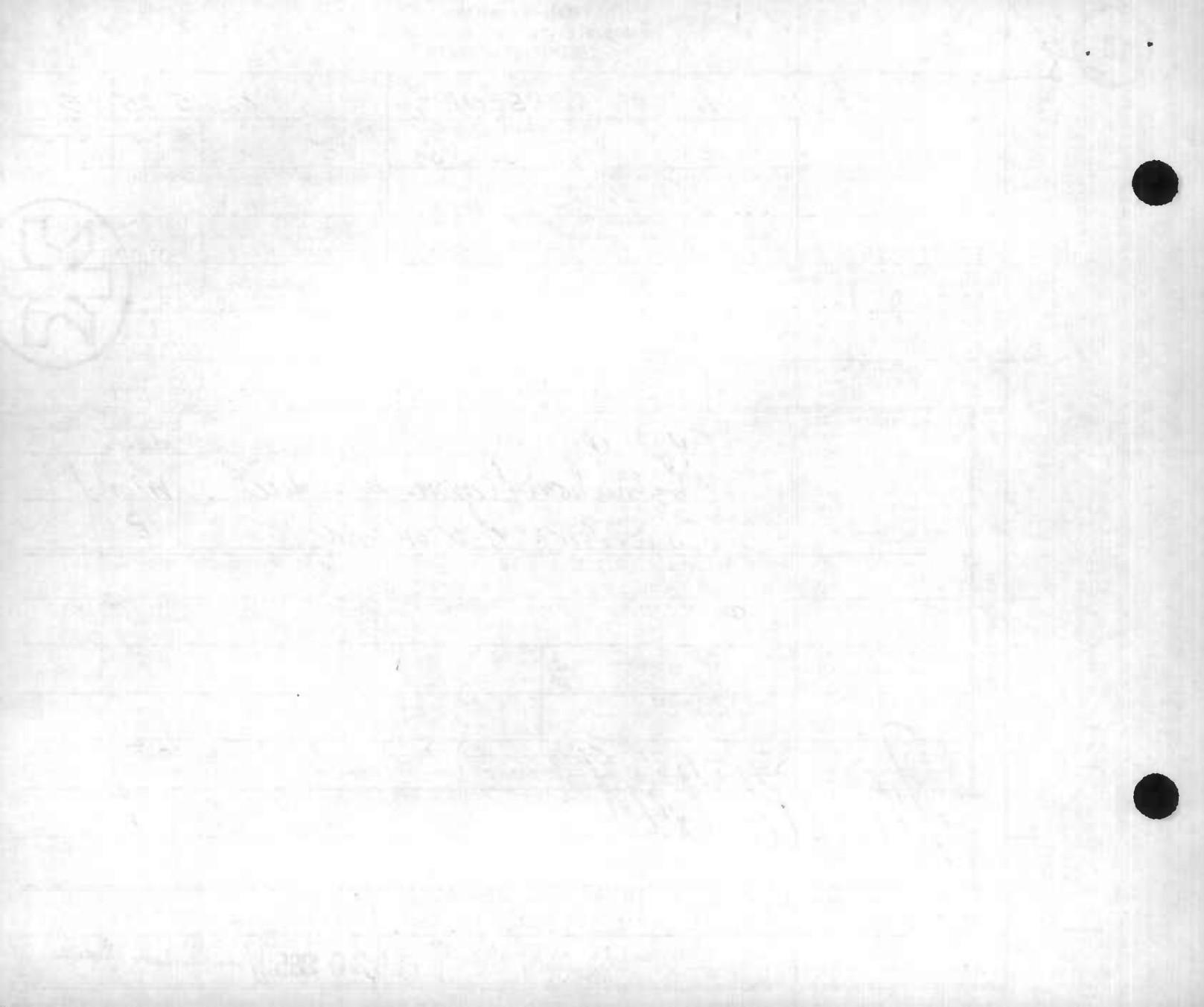
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and Item 2 should be filed within 72 hours after death, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 3 is checked, the medical examiner must be notified of cause.

### MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8503506			
					REG. NO.			
1 - STATE REGISTRAR	FIRST <b>ELLY</b>	MIDDLE <b>N</b>	LAST <b>WARGENAU</b>	2a DATE OF DEATH	MONTH <b>02</b>	DAY <b>15</b>	YEAR <b>85</b>	2b HOUR <b>7:30 PM</b>
I. DECEASED NAME (TYPE OR PRINT)	3. SEX <b>FE</b>	4. RACE <b>CAUC.</b>	5. DATE OF BIRTH MONTH <b>01</b> DAY <b>31</b> YEAR <b>00</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS. DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GERMANY</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b>	10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSP.</b>	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>WEAVER</b>	12b KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>	
13a STATE <b>MARYLAND</b>	13b COUNTY <b>A.A.</b>	13c CITY OR TOWN <b>ANNAPOLIS</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <b>210 HILLTOP LANE 21403</b>				
14. FATHER'S NAME FIRST <b>GEORGE</b>	MIDDLE	LAST <b>MOTEZIKAT</b>	15. MOTHER'S MAIDEN NAME FIRST <b>OLGA</b>	MIDDLE	LAST <b>KAIREIS</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>	16b SOCIAL SECURITY NO. <b>217-05-1031</b>	17 INFORMANT <b>ELLY WAGNER</b>	ADDRESS <b>WEST GERMANY</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>			
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Obstruction of common bile duct</b>					<b>month</b>			
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of Pancreas</b>					<b>2</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED <b>WHILE AT WORK</b>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>2/11/85</b> , to <b>2/15/85</b> , 19 <b>85</b> , to <b>2/15/85</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>2/15/85</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.								
22b SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED			
22d PHYSICIAN'S NAME	22e ADDRESS							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>	23b DATE <b>2/20/85</b>	23c NAME OF CEMETERY OR CREMATORIAL <b>WESTVIEW MEM. PK.</b>	23d LOCATION CITY OR TOWN <b>BALTIMORE</b>	23e COUNTY	STATE			
24 FUNERAL DIRECTOR NAME <b>HARDESTY FUENRAL HOME</b>	ADDRESS <b>12 RIDGELY AVE ANN., MD</b>	25a DATE REC'D. BY REGISTRAR <b>FEB 20 1985</b>	25b REGISTRAR'S SIGNATURE <b>Julia Davidson-Fandell</b>					
DPHM - 16 60M 7/84 (VRA 15, 4)								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 03507																							
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR																							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			Feb. 24 1985			M																				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS																					
Male			White			Dec. 21, 1916			68			YRS.		MONTHS DAYS HOURS MIN.																					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Anne Arundel MD.																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																				
Annapolis			Anne Arundel General Hospital									Lawyer			Insurance																				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			ZIP CODE																				
MD			AP			Annapolis						308 S. Cherry Grove Ave			21401																				
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			ADDRESS			LAST																				
Alexander B.						Way			Della			Same as			Irving																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u>			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
Yes			1WW II			021-01-6125A			Kathleen C. Way-						21-220																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) <u>Bronchovascular accident</u>			DUE TO, OR AS A CONSEQUENCE OF			(c) <u>cardiovascular disease</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																				
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED									21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21g. LOCATION STREET			21h. CITY OR TOWN			21i. COUNTY			21j. STATE		
21k. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21l. DATE									21m. SIGNATURE			22a. PHYSICIAN'S NAME (TYPE OR PRINT)			22b. DEGREE			22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED											
22e. ADDRESS			22f. BURIAL, CREMATION, REMOVAL (SPECIFY)									22g. NAME OF CEMETERY OR CREMATORIAL			22h. LOCATION CITY OR TOWN			22i. DATE REC'D. BY REGISTRAR			22j. REGISTRAR'S SIGNATURE														
22k. DATE			22l. NAME									22m. ADDRESS			22n. ADDRESS			22o. DATE			22p. SIGNATURE														
23a. BURIAL, CREMATION, REMOVAL			23b. DATE									23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. DATE			23f. SIGNATURE														
24. FUNERAL DIRECTOR NAME			24b. ADDRESS									24c. ADDRESS			24d. ADDRESS			24e. DATE			24f. SIGNATURE														
BP			Burial Feb 21 1985									Maryland Veteran			Crownsville A.A.			Feb 26 1985			Julia Davidson Pendall														
DHMH - 16 50M 4/83 (VRA 15, 4)			Taylor Funeral Chapel - Annapolis, MD																																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be informed.

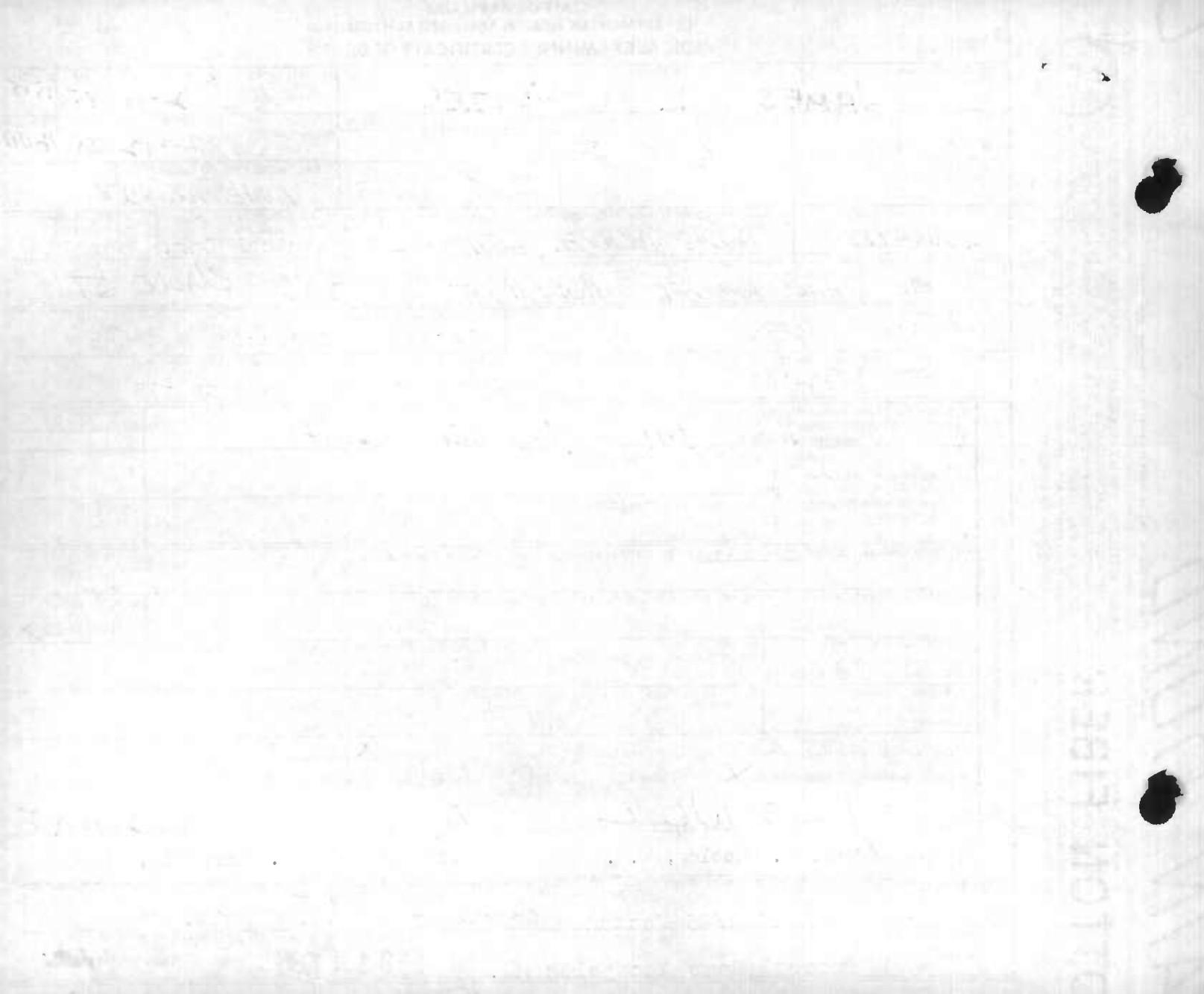
## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 3 5 0 8			
										REG. NO.			
1. DECEASED NAME FIRST MIDDLE LAST <i>ANNA B. B. WERNETH</i>										2a DATE OF DEATH MONTH DAY YEAR <i>FEBRUARY 8 1985</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>22 1916</i> MONTH DAY YEAR <i>2 3 19 16</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>68</i> YRS. MONTHS DAYS		2b. HOUR <i>8:30 A.M.</i>					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County MD</i>							
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Anne Arundel General Hospital</i> (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION <i>Housewife</i> (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>					
13a STATE <i>Maryland</i>		13b COUNTY		13c CITY OR TOWN <i>Baltimore</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <i>4803 Edgar Terrace 21214</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>George W. Wood</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Estelle Frank</i>											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>212-03-2401</i>		17. INFORMANT <i>Paul J. Werneth</i>		ADDRESS <i>Balt. Md. 21206 4005 White Ave. Apt. A-1</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sept. I. Cerebral</i> (c) <i>Recurrent urinary tract infection</i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Aspiration</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the physician) attended the deceased from <i>1/1/85</i> to <i>1/30/85</i> , that (I) (we) last saw the deceased alive on <i>1/1/85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) view the body after death.										22c. DATE SIGNED <i>2/10/85</i>			
22b. SIGNATURE <i>Donald C. Rose, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Donald C. Rose, M.D.</i>		22e. ADDRESS <i>1616 First St. Annapolis 21403</i>											
23a. BURIAL, CREMATION, REMOVAL SPECIAL <i>Burial</i>		23b. DATE <i>2/11/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Moreland Memorial</i>		23d. LOCATION CITY OR TOWN <i>Baltimore</i>		23e. COUNTY <i>Maryland</i>		STATE			
24. FUNERAL DIRECTOR NAME <i>Leonard J. Ruck, Inc.</i>						ADDRESS <i>5305 Harford Road</i>		25a. DATE REC'D. BY REGISTRAR <i>FFB 11 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Werneth</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 03509				
1- STATE REGISTRAR																
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2a. DATE KNOWN OF EST- DEATH MATED					
JAMES L. WETZEL											<input checked="" type="checkbox"/> 2-12-1985					
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD				
MALE		CAUC		10 17 34		50 yrs.						2-12-1985				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		USA		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Anne Arundel								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Annapolis		Anne Arundel General										Electrical Eng.				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY						
MD		Anne Arundel		Annapolis		YES <input checked="" type="checkbox"/>		226		Claude St.						
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Franklin		Wilson		Wetzel		Betty		215-30-7202		Susan Wetzel		Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <u>M1 - Cardiac arrest</u>																
DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.																
(b)																
DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
													<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM ETC.)		21f. LOCATION STREET								CITY OR TOWN		COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>		and in my opinion											
ACTUAL SIGNATURE <u>James E. Wheeler</u>			TITLE (SPECIFY) M.D.		MEDICAL EXAMINER <u>Dr. James E. Wheeler</u>								DATE SIGNED <u>2-14-85</u>			
EXAMINER'S NAME James E. Wheeler, M.D. (TYPE OR PRINT)			ADDRESS 910 Primrose Rd. Annapolis, 21403													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 12/14/85		23c. NAME OF CEMETERY OR CREMATORIAL Westview Crematory								23d. LOCATION CITY OR TOWN Balt.		COUNTY	STATE
Cremation													Balt.		Balt.	Md.
24. FUNERAL DIRECTOR NAME Hardesty			ADDRESS Funeral Home Annapolis Md.		25a. DATE REC'D. BY REGISTRAR FEB 14 1985								25b. REGISTRAR'S SIGNATURE <u>Jane Davidson-Randall</u>			
BP _____																
DHMH - 17 (VR A15 ME (5)) 20M 4/82																

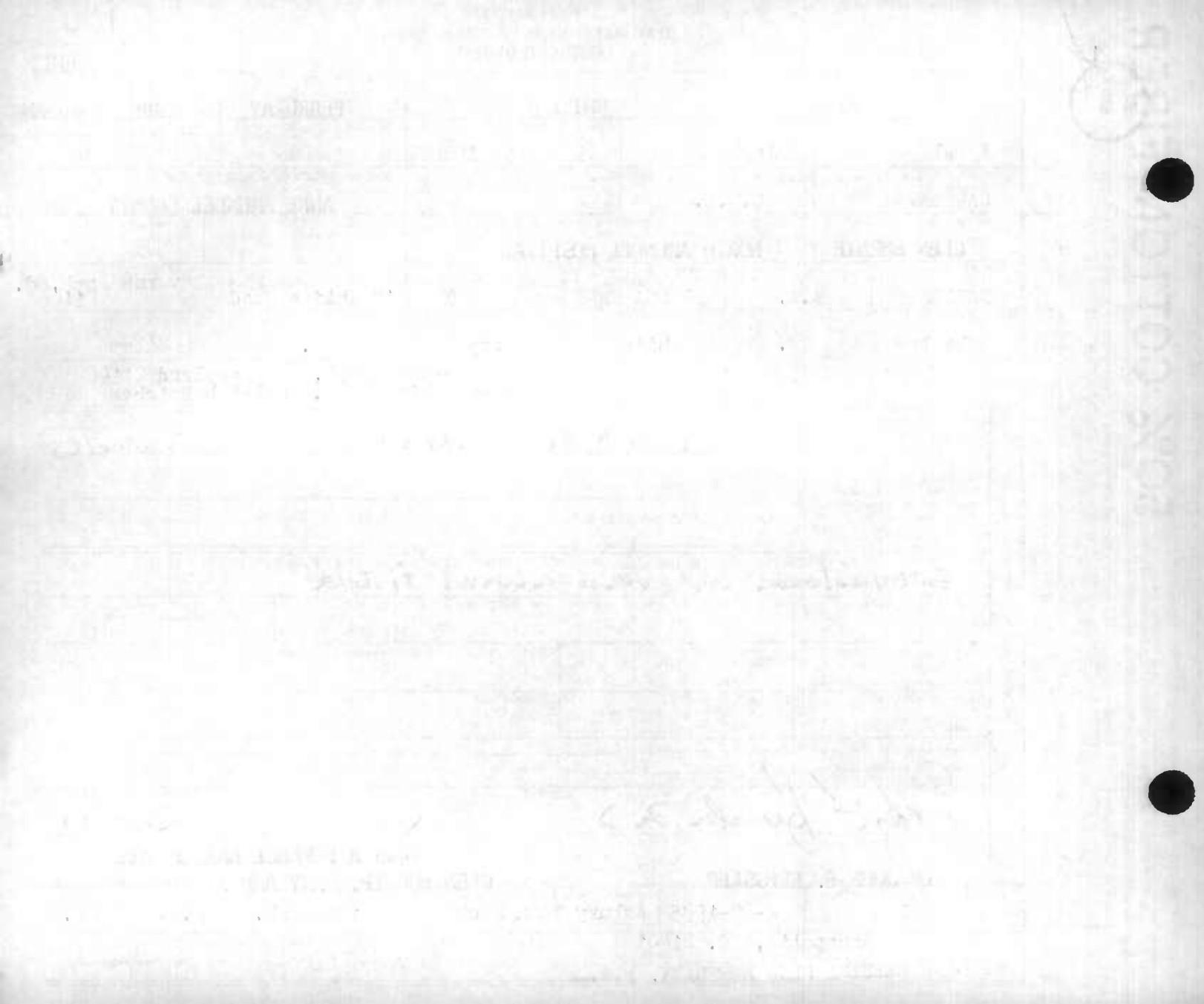


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 3 5 1 0	EDT				
1 - FOR STATE REGISTRAR			REG. NO.														
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
ALMA					WHITE	FEBRUARY			16, 1985		1046 AM						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			Black			MONTH 9 DAY 9 YEAR 1904			80			MONTHS		DAYS			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			HOURS		MIN.			
MARYLAND			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			ANNE ARUNDEL COUNTY MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE			NORTH ARUNDEL HOSPITAL														
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			Severna Park Md. 21146				
MARYLAND			A.A.		SEVERNA PARK					13 Whites Road							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST						
Charles			A.		White	Mary			Mary	E.	Giles						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
						Severna Park, Bernard White 85 W. Earleigh Heights Road			Maryland 21146								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			CARDIAC ARREST									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												3 minutes					
(b)																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Intero-cutaneous and vesico-cutaneous fistulae</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																	
22b. SIGNATURE <i>John F. Kressler, M.D.</i>			22c. DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>2/16/85</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS						7445 A FURNACE BRANCH ROAD								
DR. JOHN F. KRESSLER									GLEN BURNIE, MARYLAND 21061								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2-20-1985			23c. NAME OF CEMETERY OR CREMATORIAL Asbury Town Neck			23d. LOCATION Severna Pk.			COUNTY	STATE				
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.			ADDRESS			25a. DATE REC'D. BY REGISTRAR FEB 22 1985			25b. REGISTRAR'S SIGNATURE <i>Richard Pendle</i>								

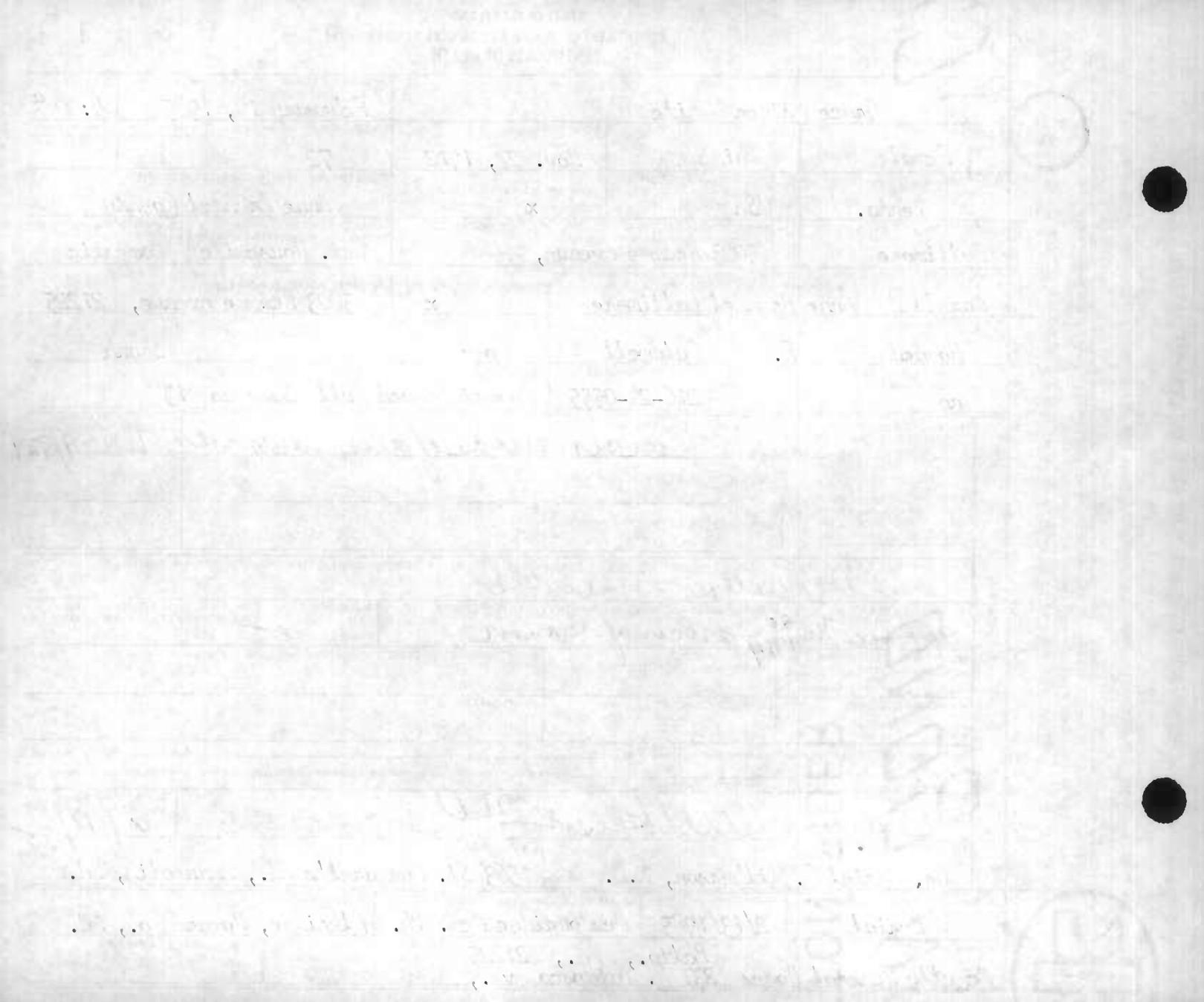


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										850351			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR		
Grace Esther White						February 10, 1985					4:00 AM		
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			White		Nov. 27, 1912	72		MONTHS	YEARS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Penns.			USA			Anne Arundel County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore			5003 Kramme Avenue,		Ret. Housewife		Domestic						
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE							
Maryland			Anne Arundel	Baltimore		5003 Kramme Avenue, 21225							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
Howard			E.	Caldwell	Cora	Shank							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT	ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
no			216-24-0555		Robert Edward Dull	Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Carcinoma of descending colon Nov 9, 1984			
DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Diseases & Injuries													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
approx Nov 20 Cancer of colon													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 or PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Daniel Wilkerson MD			
22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22d. DATE SIGNED 2/14/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
Dr. Daniel C. Wilkerson, M.D.			1563 St. Margaret's Rd., Annapolis, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN	23e. COUNTY		23f. STATE					
Burial			2/13/1985	Meadowridge Mem. Pk.	Elkridge, Howard Co., Md.								
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
McGilly Funeral Homes			Balto., Md., 21225		Feb 13, 1985								
			237 E. Patapsco Ave.										



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

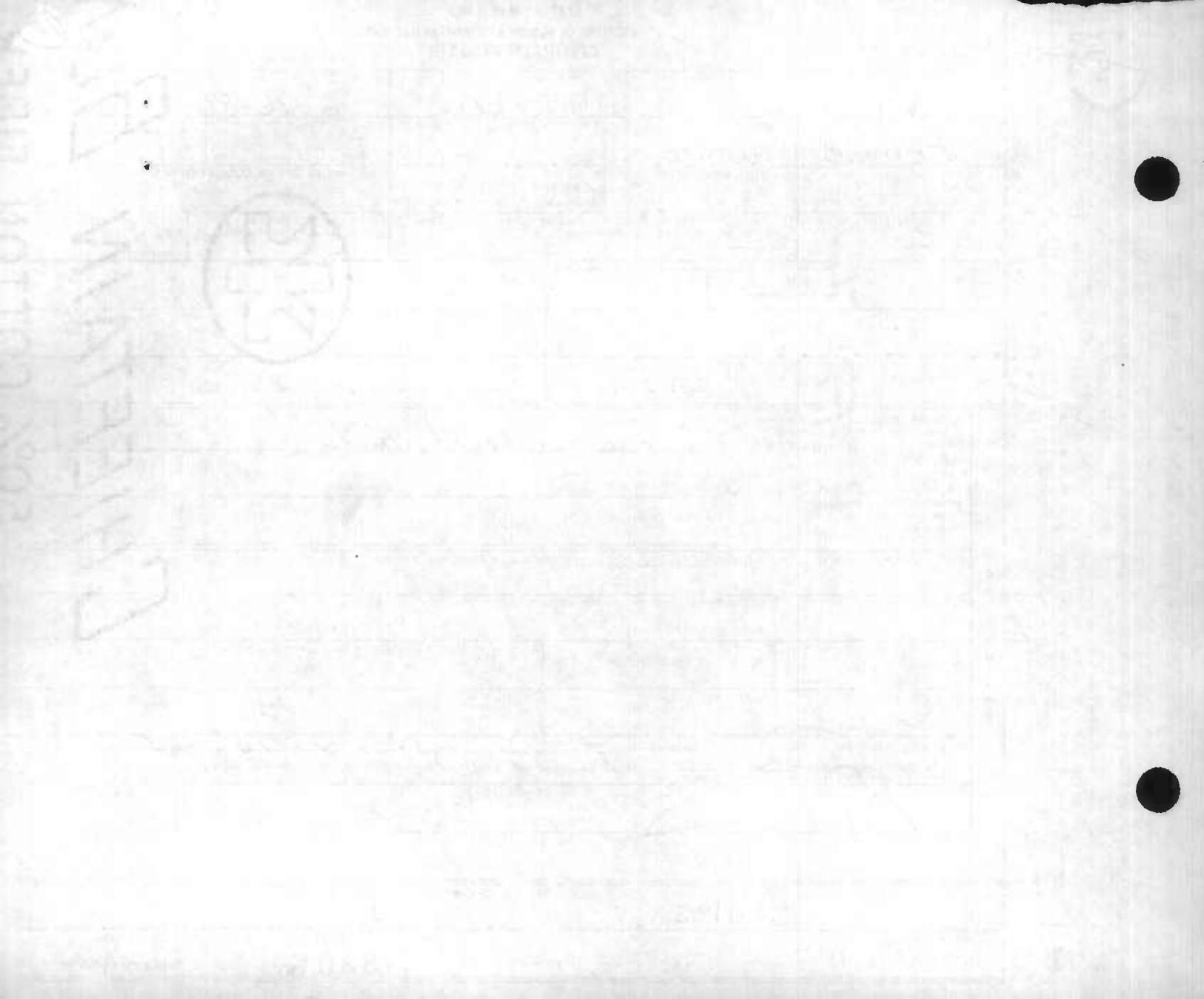
1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<i>Virginia</i>					<i>Whittaker</i>	<i>2-16-85</i>				<i>1253pm</i>
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.	
<i>Female</i>	<i>White</i>	<i>Aug. 7, 1909</i>			<i>75</i>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
<i>Va.</i>	<i>USA</i>				<i>AACo</i>					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<i>Annapolis</i>	<i>AA General</i>			<i>Clerk</i>			<i>Dental</i>			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13c. STREET ADDRESS / ZIP CODE				
14a. STATE	14b. COUNTY	14c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>xx</i>			Rte. 1				
<i>Va</i>	<i>Montgomery</i>	<i>Christiansburg</i>								
15. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
<i>Charles Robert Bibb</i>			<i>Mattie Jane Linkous</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN						16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
						<i>231 32 7431</i>		<i>Shirley Bishop, Annapolis, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>										
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED <i>AT HOME</i> <input type="checkbox"/> <i>NOT WHILE AT WORK</i> <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (i) this hospital attended the deceased from <i>2-15-1985</i> to <i>2-16-1985</i> , that (ii) we last saw the deceased alive on <i>2-16-1985</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) did not view the body after death.										
22b. SIGNATURE <i>[Signature]</i>						DEGREE		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		<i>219185</i>		Christiansburg Cemetery		Christiansburg		Montg.	Co. Va	
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Hardesty FH, 12 Ridgely Ave, Annapolis, Md. 21401				<i>FEB 20 1985</i>		<i>Julia Davidson-Pandell</i>				

DO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be held within 72 hours after death. If held longer than 72 hours, it should be destroyed.

IMPORT ANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified.



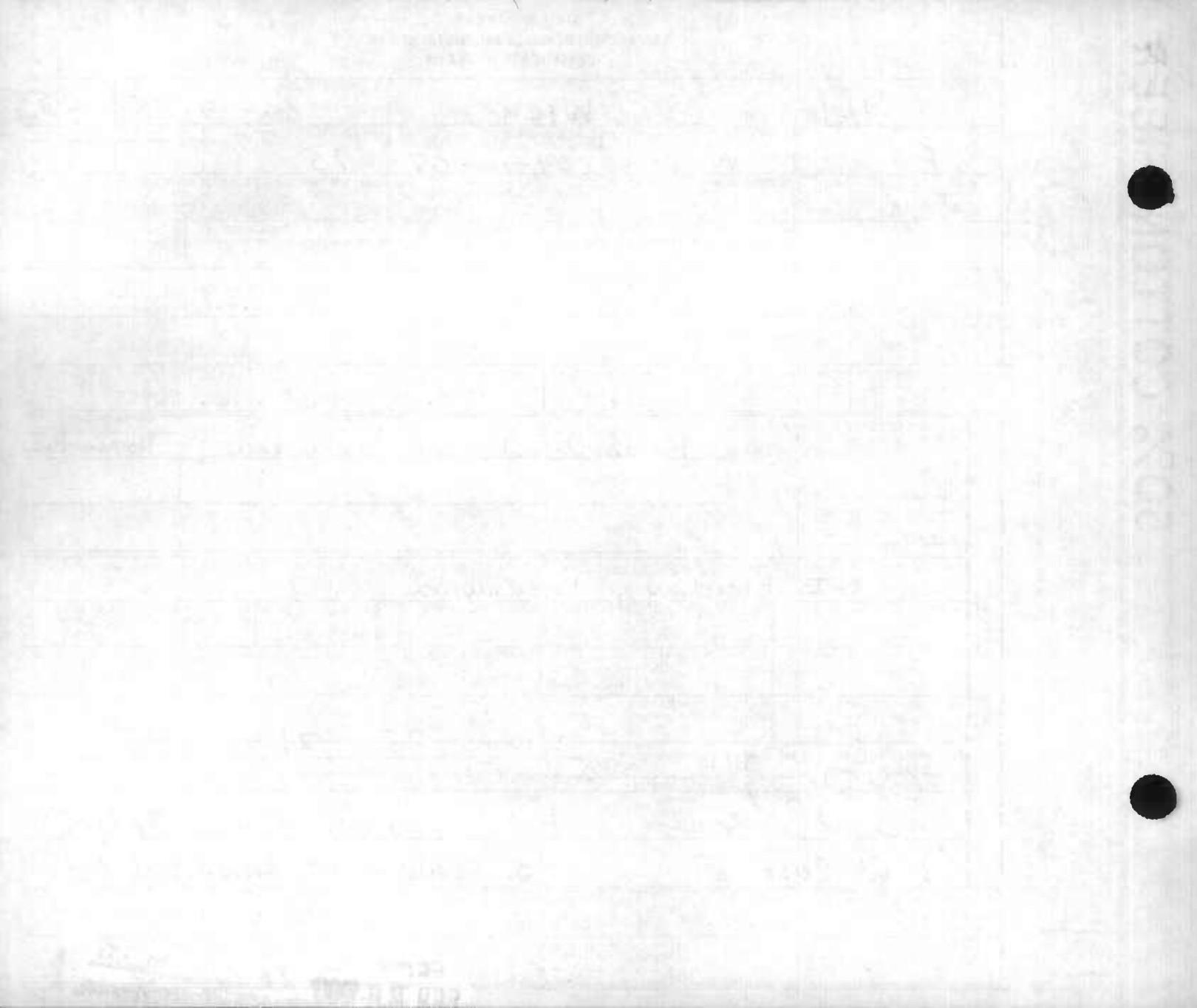
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03513					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Helen E. WICK						02-19-85						9:55 AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
F EMAL		WHITE		MONTH	DAY	YEAR	75			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
MONTANA		USA					ANNE ARUNDEL COUNTY								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IN SUBDIVISION, STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS OR INDUSTRY)			12b. KIND OF BUSINESS OR INDUSTRY								
ANNAPOLIS		ANNE ARUNDEL GENERAL HOSPITAL		HOUSEWIFE											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13. STATE		13c. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE								
NORTH DAKOTA		LAMOURE		LAMOURE			411 3rd S.E. 62458 99999								
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST					
LEVI				MACK	NELLIE					BARRETT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			12203 MACKELL LANE								
NO		519-24-8145		JAMES E. WICK BOWIE, MD. 20715											
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Breast Carcinoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 months</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>GI Bleeding, Pneumonia</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>2/19</u> , 19 <u>85</u> , to <u>2/19</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2/19</u> , 19 <u>85</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. If we did not see the body after death, <input type="checkbox"/>															
22b. SIGNATURE <u>E W COLE III</u>										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>2/19/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN	
BURIAL		51 FRANKLIN ST ANNAPOULS Md.			2-23-85			ROSEHILL			LAMOURE LAMOURE NORTH			STATE	
24. FUNERAL DIRECTOR ROBERT E. EVANS		1212 WEST STREET ANNAPOLIS, MD. 21401			25a. DATE REC'D. BY REGISTRAR <u>FEB 26 1985</u>			25b. REGISTRAR'S SIGNATURE <u>JULIA DAVIDSON RENDALL</u>							
DHMH - 16 60M 7/84 (VRA 15, 4)															



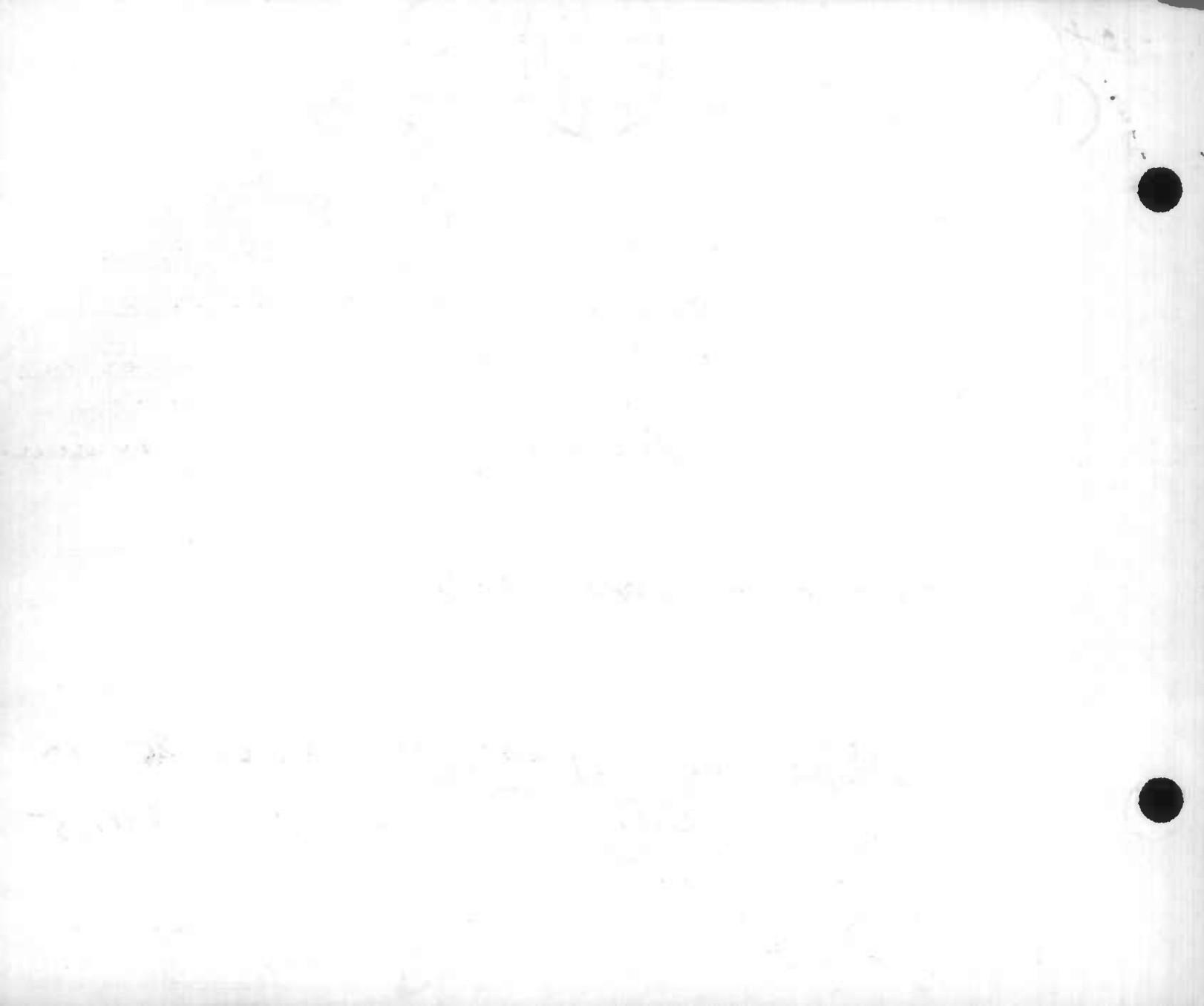
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be deposited at the burial/tranport permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 showing injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85	03514									
										REG. NO.	EST									
1 - STATE REGISTRAR			F			1. DECEASED NAME			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
						RUSSELL			NMN		WILLIAMS	FEBRUARY			16,	1985		620 AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS					
MALE			WHITE			MONTH DAY YEAR MAY 05, 1899			85 YRS.			MONTHS DAYS			HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
MARYLAND			U.S.A.						ANNE ARUNDEL COUNTY											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
GLEN BURNIE			NORTH ARUNDEL HOSPITAL			STEAMFITTER			B.G.&E.											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STREET ADDRESS / ZIP CODE										
13a. STATE MD			13b. COUNTY A.A.			13c. CITY OR TOWN GLEN BURNIE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 102 MAIN AVE. S.W. 21061								
14. FATHER'S NAME FIRST ALFRED			MIDDLE J.			LAST WILLIAMS			15. MOTHER'S MAIDEN NAME FIRST MARY			MIDDLE E.			LAST DOVE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT (niece-in-law) MARGARET V. GLAS			ADDRESS 102 MAIN AVE. S.W.			GLEN BURNIE, MD 21061								
YES			WWI			212.05.4474														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>																				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Hypokalemia</i>																				
DUE TO, OR AS A CONSEQUENCE OF (c) <i>COPD</i>																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Hypokalemia</i> <i>copd</i> <i>CHF</i>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that (1) I (or my hospital) attended the deceased from 2/16/85, 19 85, to 2/16, 19 85, that (1) (we) last saw the deceased alive on 2/16/85, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death.																				
22b. SIGNATURE <i>DAVID A. SCHWARTZ, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/16/85											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 200 GLEN BURNIE, MARYLAND 21061																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE FEB. 18, 1985			23c. NAME OF CEMETERY OR CREMATORIUM GLEN HAVEN MEM. PARK			23d. LOCATION CITY OR TOWN GLEN BURNIE			COUNTY STATE A.A. Pendleton MD								
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME			ADDRESS GLEN BURNIE, MD 21061			25a. DATE REC'D. BY REGISTRAR FEB 19 1985			25b. REGISTRAR'S SIGNATURE <i>John Pendleton</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If Item 21 is marked as Item 1B showing any injury, or other traumatic event, medical certification should be obtained.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3) should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8503515 EST		
												REG. NO.		
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST WILLIAM	MIDDLE MORTON	LAST WOLF	2d. DATE OF DEATH			MONTH FEBRUARY	DAY 23, 1985	YEAR AM 0915	7b. HOUR AM	
							MONTH DEC	DAY 26	YEAR 1920					
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH MONTH DEC			DAY 26	YEAR 1920	6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b>							
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SHEET METAL</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRIAL</b>							
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>HOWARD</b>	13c. CITY OR TOWN <b>SAVAGE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>8334 WOODWARD STREET 20763</b>						
14. FATHER'S NAME FIRST <b>William</b>	MIDDLE 	LAST <b>Wolf</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Estella</b>			MIDDLE 	LAST <b>Whitehurst</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO <b>N/A</b>	17. INFORMANT <b>Olga Stanton</b>			ADDRESS <b>SAMES AS #13e</b>									
18. CAUSE OF DEATH (Enter only one cause per line for item 1b, 1c, and 1c <sup>o</sup> ) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arthritis</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1c														
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1c OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												22c. DATE SIGNED		
22b. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
22c. ADDRESS <b>7845 OAKWOOD ROAD SUITE 200</b> <b>GLEN BURNIE, MARYLAND 21061</b>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>2/26/85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>MT OLIVET CEMETERY</b>			23d. LOCATION CITY OR TOWN <b>WASHINGTON</b>			STATE <b>MD.</b>						
24. FUNERAL DIRECTOR NAME <b>Fleck Funeral Home</b>	ADDRESS <b>7601 SANDY SPRING Rd LAUREL Md. 20707</b>				25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
			<b>FEB 26 1985</b>						<i>Lilia Davidine Anderson</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. In the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Please I need 2 copies be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified at this time.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 3 5 1 6  
EST

1. DECEASED NAME (TYPE OR PRINT)		FIRST BEATRICE	MIDDLE Grimes	LAST WYATT	2a. DATE OF DEATH MONTH FEBRUARY	DAY 16, 1985	YEAR 1985	2b. HOUR 250 AM
3. SEX  Female	4. RACE  White	5. DATE OF BIRTH MONTH March DAY 9, 1906 YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE, GIVE ADDRESS) NORTH ARUNDEL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Practical Nurse			
13a. STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7885 Gordon Court, Apt. 570 21061			
14. FATHER'S NAME FIRST Maurice	MIDDLE E.	LAST Grimes	15. MOTHER'S MAIDEN NAME Sarah		MIDDLE Virginia	LAST Coleman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 329-22-0268	17. INFORMANT Edmon John Wyatt 4915 Montgomery Road,		ADDRESS Ellicott City, Md. 21043				
18. CAUSE OF DEATH (Enter only one cause per line) (TYPE OR PRINT) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Severe Chronic Obstructive Pulmonary Disease								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>2-9-85</u> to <u>2-16-85</u> , 1985, that (I) (we) last saw the deceased alive on <u>2-7-85</u> , 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.								
22b. SIGNATURE <u>Maurice J.W.</u>	22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN CHAC KUMKAL V. CYRIAC, M.D.	22e. ADDRESS 14 WILLIAM AVENUE SUITE 101 GLEN BURNIE, MARYLAND 21061	22f. DATE SIGNED 2-17-85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/19/1985	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery			23d. LOCATION CITY OR TOWN Baltimore City, Md.	23e. COUNTY STATE		
24. FUNERAL DIRECTOR NAME McCullly Funeral Homes	ADDRESS 237 E. Patapsco Ave., Baltimore, Md. 21225	25a. DATE REC'D. BY REGISTRAR FEB 19 1985			25b. REGISTRAR'S SIGNATURE Leah Davidson-Pendell			

